

Have recent changes in mental health
legislation and policy provided any
positive gains for service users in
England and Wales?

M.Phil Thesis

Stephen Paul Swann

Department of Law and Criminology
Aberystwyth University

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Have recent changes in mental health legislation and policy provided any positive gains for service users in England and Wales?

Introduction

The purpose of this thesis is to critically review some of the recent changes in mental health legislation and policy that have been implemented by New Labour. It will begin by considering the background to today's contemporary mental health system from a historical context. The thesis will then consider whether or not the new Mental Health Act 2007 has made any positive gains in terms of rights for Patients and those that care for them? Have the needs of all interested stakeholders been realised? And finally, is compulsory treatment in the community a viable alternative to continued hospitalisation. The third part of the thesis will re-evaluate the public's perception of the mentally ill by considering the place of various actors that have contributed to what has effectively become an urban mythology. The thesis will then consider the position from a service users (patient's) standpoint. The nature of the doctor patient relationship and how it can impact upon consent to treatment. The thesis will also reflect upon some service users experience of what it means to be mentally ill and how this relates to their recovery. The final part of the thesis will consider recent changes in proposals to a new strategy to replace the existing/previous framework and the economic justification for what could amount to a paradigm shift in policy.

Chapter one will consider the development of mental health law from a historical perspective, from its early beginnings in the Chancery courts, the importance of the common law through to the post-war period of social care and the development of community legislation under new Labour. Mental health law is at once the practical exercise of necessity and at the same time a continuing compromise between moral, political, and economic factors. It functions as a formal expression of the state's authority towards individuals with mental disorders, giving substantive authority to restrict and impose

limitations on individual freedom, with the potential to detain indefinitely. In addition, the legislation has considerable impact on the implementation of policy in determining the need for resources in the delivery of services.

Chapter two will continue from chapter one by reviewing some of the gains and losses brought in by the new legislation. The chapter will consider one overriding question; has the 2007 Act improved the 1983 Act for service users and their families and carers and achieved a better outcome for those who have to live with the consequences? This question will be approached from three separate perspectives. Firstly, has the new Act provided any constructive gains in terms of political and civil rights (PC rights) and economic, social and cultural Rights (ESC rights)? Secondly, has the new Act failed to address the aspirations of those who are primarily affected by the legislation? And finally, is the introduction of Supervised Community Treatment, questionably the most controversial part of the amending legislation, a feasible alternative to continued detention for some patients?

Chapter three will critically review the development of the relationships between various parties that contribute towards policy. This chapter considers the public's attitude towards mental health. In broad terms, the discussion begins with a brief overview of the legislation that underpins the system, explores some of the questions that are seen as deep-seated flaws within the system and the effect that such misgivings have on public opinion. The aim is to provide a forum for discussion as to how and why - despite the introduction of *Care in the Community* as a working policy - the public in general continue to view mental illness from a negative perspective and importantly, how such attitudes can be addressed responsibly by some of the actors within this specific area of education. The chapter will consider the impact that cinematography; the media and the press have had in contributing to what has helped to shape the public's image of what it is to be mentally ill. And finally, is it possible to change public opinion through a program of targeted education. The chapter will also consider two case studies that have been prominent in the media over the last two decades.

Chapter four will considers the difficulties experienced by service users and other stakeholders relative to their positions as actors in what is perceived to be the primary function of mental health regulation. The aim here is to demonstrate that from a service users perspective, there are some fundamental issues that the current rationale within the existing care structure fails to address. The chapter will argue that much of the implementation of the MHA today is affective rather than effective and falls short of what is required for any semblance of a cohesive service. The chapter will discuss the adverse effects that the legislation has on those to whom it is principally directed. How on one hand, such effects have contributed towards institutional entrenchment by the psychiatric profession, whilst on the other, have in practice provided only limited protection for the individual. At a subjective level, the discussion will consider the real effect of the doctor patient relationship when viewed in context.

The second part of the chapter will further consider some of the issues raised in section one from the personal experiences of service users relates to discrimination, disability, and the implications for social exclusion. It will also consider using a social model of disability as a potential forum in gaining Social rights. The final section will consider whether in-patient care and subsequent discharge procedures are seen as therapeutic or damaging from service users standpoint.

The final chapter will consider the cost and means of delivering mental health services, from a rights perspective. The chapter will consider how ESC rights can be extended beyond the remit of the MHA 2007. What is the economic cost of mental illness? Is there a place for wider involvement and cooperation with NGO's in mental health care? And finally, is the apparent move towards a more democratic sharing of power among stakeholders as outlined in Labour's *New Horizons* strategy document and the Coalition's *No health, without mental health* consultations process indicative of a long-term paradigm shift?

Methodology:

The purpose of this Thesis is to critically review the impact that recent changes in Mental Health Legislation and Policy in England and Wales have had on those individuals who are exposed to mental health services as service users and to establish if the changes in legislation and Policy have provided any positive gains for service users.

The Research method is for the most part library based, drawing upon primary sources of data including Statutes, Government Reports, Policy Documents, Consultation Papers, and relevant case law. Further reading has incorporated an extended review of Policy Documents, reports and Briefing Papers from Non-Governmental Organisations, many of which have been commissioned by Government Departments. Other secondary sources include academic monographs, journal articles and other published material. Due to the nature of the subject matter, additional research has included media sources such as newspapers, vocational publications, television and the cinema. Tertiary sources of material have included Internet articles and websites. Where the author has been unable to access primary sources directly but has accessed those sources through secondary sources then the author has endeavoured to cite the materials accordingly.

The author has had considerable personal experience of the subject area (mental Health) in having worked as Support Worker and Health Care Assistant for a local authority social services department. The author has also periodically worked as a volunteer for a number of charitable organisations in the field of disabilities, learning difficulties and mental health. It is this experience that first prompted the author to consider writing this Thesis.

Chapter 1: A historical overview of the contemporary mental health system.

Introduction

To gain an understanding of the contemporary position of the mental health system it is necessary to appreciate that the law as it stands today, is historically, on one hand, highly developed although somewhat controversial in the area of restrictive confinement, but on the other, a loose amalgam of half integrated policy and legislation in dealing with mental health and the community. Thus, it is misleading to think of the state provision of mental health services as a single system. It functions as a formal expression of the state's authority towards individuals with mental disorders, giving substantive authority to restrict and impose limitations on individual freedom, with the potential to detain indefinitely. In addition, it also serves as a vehicle for the implementation of policy in the same way that decisions are taken to build new schools or fund special educational programmes. Mental health law is at once the practical exercise of necessity and at the same time a continuing compromise between moral, political and economic factors. As a central theme, the chapter will reflect upon the competing tensions between the state's objective responsibilities and husbandry regarding resources against the continually evolving subjectivity of civil rights and individual liberties.

1.1 The Origins of today's mental health regime

In order to understand the existing regime it is necessary to have a critical appreciation of its history. From medieval times through to the early modern period of the Enlightenment, the provision for care of the mentally disordered generally fell outside the realm of statute; it was not until the latter half of the seventeenth century and early part of the eighteenth century that the insane as a class became the subject of statutory regulation. Historically, proceedings of incapacity fell under the ordinance of the royal prerogative, with power over the affairs of lunatics and idiots, once proven, vested in the

authority of the monarchy.¹ Though originally administered by the Lord Chancellor and later through a panel of three Commissioners of Lunacy, the powers were eventually moved to the jurisdiction of the Chancery Courts; though in practice, general arrangements for the care or incarceration of lunatics and idiots without substance was often a matter for the local magistrate under the common law. As Blackstone states in his Commentaries on the Laws of England:

“It was the doctrine of our ancient law, that persons deprived of their reason might be confined till they recovered their senses, without waiting for the forms of a commission or other special authority from the crown: and now, by the vagrant acts, a method is chalked out for imprisoning, chaining, and sending them to their proper homes.”²

Thus, out of a sense of public necessity, it had long been established that there was compelling justification for the legitimate use of compulsion against those who seemed to be afflicted with madness, firstly for the protection of society and secondly out of a sense of compassion for the afflicted individual. The notion of compassion was nevertheless balanced in reflecting society's interests over those of the individual as the following extract from a petition at Ormskirk Quarter Sessions illustrates:

‘...in respect of John Pateson, who had fallen into a sullen, sad, melancholic and would not go indoors or eat or wash himself. His neighbours discovered that his head had become infested with maggots and decided something had to be done to help him. They forced him into a house and paid a woman to dress and take care of him. The local magistrates ordered that the costs should be paid from public funds. The churchwardens and overseers were ordered to make an assessment and provide out of poor rates for his care until he recovered or died’.³

Though the above passage suggests an earnest regard for the welfare of the individual, in practice, the position was very much one of disposal in the context of nuisance rather than any notion of human rights or therapeutic benefit for the afflicted individual.

¹ Originating in *De Prerogativa Regis* (1324) c. ix. x. Giving the King jurisdiction over the persons and property of ‘idiots’ and those who ‘who happen to fail of their wit’. Walker, N. (1972) *Crime and Insanity in England*, p. 25.

² Blackstone, W. (1765-69), *Commentaries on the Laws of England*, London, Clarendon Press, Book Four, Chapter Two, ii. <http://www.lonang.com/exlibris/blackstone/> Accessed 27th July 2011.

³ Hunter, R.A. and Macalpine, I. (1963), *Three Hundred Years of Psychiatry, 1535-1860*, p.140.

Inevitably, changes in social attitudes towards troublesome lunatics at large in the community began 'The Great Confinement'⁴ of the insane that led to the conception of the asylum institution that was later to typify the Victorian era.

Further endorsement of the growth of a social control model was provided by the introduction of the 1714 Vagrancy Act and latterly consolidated and re-stated in the 1744 Act, which specifically allowed for the detention of 'lunatics' as the following states:

"And whereas there are sometimes in parishes, towns and places, persons of little or no estates, who, by lunacy, or otherwise, are furiously mad, and dangerous to be permitted to go abroad ... shall and may be lawful for any two or more of the Justices of the Peace of any county, town or place in England, Wales or Town of Berwick upon Tweed, where such lunatic or mad person shall be found, by warrant under their hands and seals, directed to the constables, church-wardens, and overseers of the poor of such parish, town or place, or some of them, to cause such person to be apprehended..."⁵

However, prior to the Vagrancy Acts, the insane, when confined were lodged wherever accommodation could be found for them, and whether that was the local bailey or poorhouse was dependant upon the goodwill and resources of the parish.⁶

That lunatics had now been distinguished by statute from common criminals, vagabonds and the like, undoubtedly presented a new set of problems for the good aldermen of the district in providing suitable lodgings for their newfound charges. One device adopted by parishes for the disposal of lunatics was the practice of 'boarding out' in private dwelling houses, which gradually acquired the description of 'mad' houses, with the charges being found from parish rates. Accordingly, in the second half of the seventeenth century, the practice

⁴ Foucault, M. (1967) *Madness and Civilisation*, pp. 151-71. In England, houses of incarceration for lunatics first developed in the late sixteenth century. They spread across the country in the seventeenth century as private madhouses. Then following the County Asylums Act 1828, these institutions formed the backbone of in-patient mental healthcare until Care in the Community brought about their end, most significantly, in the 1990's.

⁵ 12 Anne, c.23. An Act for reducing the laws relating to rogues, vagabonds, sturdy beggars, and vagrants, into one Act of Parliament, followed by the 1744 Act, George 2, c.5. which provided that the charge for 'curing' such persons should be met from parish funds.

⁶ As previously illustrated in John Pateson's case at page 3 above. Hunter, R.A. and Macalpine, I. (1963), *Three Hundred Years of Psychiatry, 1535-1860*, p.140.

widely became the effective method of managing lunatics and idiots and in doing so; the foundations of the private madhouse system were laid.⁷ Perhaps ironically, today's policy-makers would recognise the beginnings of the private funded initiatives that have become central in the service provider/ service user debate that is inherent in managing health services today.

There did however exist, a traditional disparity between those confined out of necessity under the common law⁸ and those, who following inquiry by a Commission of Lunacy were found to be insane and confined as Chancery Lunatics. Whilst the common law was often exercised as a matter of necessity, the jurisdiction of the Chancery Courts would perhaps be more commonly invoked to protect interests in real property, with the Crown taking responsibility for the lunatic's affairs, including accommodations. Although many families regarded confinement in 'private institutions' as a satisfactory system of management for lunatic relatives, there was some disquiet.⁹ On one hand, it played upon a family's concern to deal with a family member both humanely, effectively and without the stigma of madness being associated with the family name and on the other, that profit rather than therapeutic care was often seen as the reason for detention by the madhouse owners. However, the growing potential for the abuse of detention, often supported by relatives with questionable interests, led to serious concerns in the House of Commons over the lack of regulation. Additionally, there was considerable public concern over the harsh treatment of both pauper lunatics in workhouses and others held in private madhouses that had become manifest in the publication of articles, letters and pamphlets. In 1763, an article published in

⁷ The Madhouses Act 1774 (14 Geo. 3 c.49) set out a legal framework for regulating "madhouses." As prior to that time there were no records of how many private madhouses existed or who owned and administered them.

⁸ Inevitably pauper-lunatics, confined in parish houses under the 1601 Poor Law Act. 43 Elizabeth. 2. usually known as the Old Poor Law. The law distinguished between lunatics, who were maintained out of the poor rates, and non-paupers. It should be noted that there were many non-paupers received at similar charges to paupers, and maintained in similar conditions. Paupers were poor but non-paupers were not necessarily rich!

⁹ Parliament ordered that a Select Committee of the House of Commons should be convened to enquire into the abuse of lunatics in private madhouses. Journal of the House of Commons. 22. 2. 1763 pp. 486-489.

<http://www.webarchive.org.uk/wayback/archive/20070711230000/http://www.studymore.org.uk/mhhti m.htm> Accessed last, 12th July 2011.

the *Gentleman's Magazine*¹⁰ exposed the plight of persons held against their will under the pretext of insanity.

Following these revelations, Parliament ordered that a Select Committee of the House of Commons should be convened, stating:

"Whereas many great and dangerous abuses arose from the present state of houses kept for the reception of lunatics, for want of regulations with respect to the persons keeping such houses, the admission of patients into them and the visitation by proper persons of the said houses and patients: and whereas the law, as it now stands, is insufficient for preventing or discovering such abuses...that the present state of the private madhouses in this kingdom, requires the interposition of the legislature."¹¹

The Committee was however aware that two established remedies for such an infringement of liberty existed in English law; firstly an application to the higher courts for a writ of *habeas corpus* and secondly, a request for a Justice of the Peace to intervene. Nevertheless, in considering the various cases that were placed in evidence, it became apparent that several points were at issue; firstly the confined person was in no position to make such an appeal, secondly those responsible for the confinement generally did not advertise their actions, or allow the confined individual to communicate with those who might assist, and, thirdly any applicant to the court would have to be someone who suspected that another had been confined. As a consequence, the Committee's report made recommendations that the way in which persons were admitted, and their treatment during confinement should be the subject of further regulation. In addition, all private houses should be licensed with their details entered in a register.

Accordingly, a number of members put forward bills, most of which foundered for the want of support. However, in 1773 during a debate on a member's bill passage through the Commons, Thomas Townsend¹² noted that:

¹⁰ Nichols, J., (1763), 'A Case humbly offered to the Consideration of Parliament' *Gentleman's Magazine and Historical Chronicle*." 33, pp. 25-26.

<http://ia600208.us.archive.org/2/items/gentlemansmagazi03marc/gentlemansmagazi03marc.pdf>
Accessed 12th July 2011

¹¹ *Op. cit.* JHC. 22. 2. 1763 cols. 486-489.

¹² One of the Bills sponsors, (1733-1800), Member for Whitchurch 1754-1783, later Lord Sydeny.

"A matter of this sort had been formerly agitated in Parliaments, and was carried on with great expedition, but did not succeed owing to the part the gentlemen of the long robe took against it...I do not wish to see private madhouses suppressed, but put under such regulations, that the magistrates in the counties throughout England may have the power to see justice done to those who are unhappy enough to become inmates of those places."¹³

Undoubtedly, the long robes referred to belonged to the offices of the Lord Chancellor, but as Townsend remarked during the course of the Bill:

"It has been suggested that this Bill will abridge the power of the Lord Chancellor over lunatics....but, Sir, this is a great mistake: on the contrary, it will facilitate the operations of that court, and enlarge its power."¹⁴

Perhaps referring to the considerable revenues generated through the Chancery courts in administering the estates of Chancery Lunatics. Nonetheless, despite Townsend's support, the 1773 Bill passed through the Commons but was rejected by the Lords who deferred proceedings to beyond the end of the session. When reintroduced in the following year, with amendments by the Lords, the Bill became enacted as the Madhouse Act 1774.¹⁵ Although the President of the Royal College of Physicians in the name of the Treasurer was able to prosecute anyone (in the London metropolitan area) who kept an unlicensed house and /or admitted any patients without a medical certificate, the commission could not release a patient improperly confined. This was the traditional role of the High Courts at Westminster, for whose benefit the registers were principally kept. The court could also order special visits and reports, and examine those engaged in the execution of the Act. Private individuals could apply to the commission to find

¹³ JHC, 11.2.1773 col. 697.

<http://www.webarchive.org.uk/wayback/archive/20070711230000/http://www.studymore.org.uk/mhhti m.htm> Accessed last, 12th July 2011

¹⁴ *Ibid.*, JHC22.4.1773 cols 837-8

¹⁵ Madhouse Act 1774, 14, George 2. The Act required that private madhouses should be licensed by a commission from the Royal College of Physicians if in the City of London and throughout the rest of England and Wales by Justices of the Peace. At least once a year, the Commissioners should visit each madhouse, report on its condition, and record the details in the County Register. The Secretary to the Commissioners was to be sent a notice of the admission of every lunatic who was not a pauper to any licensed house in England and Wales.

out if someone was registered as a patient and, if so, where he or she was detained.

That the regulations of the 1774 legislation intended to change the position of lunatics confined in private madhouses and charitable hospitals for the better is clear, private madhouses were now subject to statutory regulation. However the Act proved difficult to affect in practice and did not apply to those held in single confinement and more significantly pauper lunatics in the workhouses.¹⁶

Arguably, the Act had the prevention of misdirected detention more in mind than the therapeutic care of the insane. As a consequence, the shortcomings of this legislation, (although laudable in its intentions), contributed little to address the defects of the private madhouse system. For the poor, the necessity of economic dependency meant that in general, succour could only be found at the door of the workhouse. For the pauper lunatic, with no means of support, the issue of their illness would generally need to be severe enough to warrant intervention by the common law, with the local jail or poorhouse often the end result.

There had however, been a parallel movement for the founding of institutions for the insane by public subscription, notably, Guy's Hospital's wards for chronic lunatics, St Luke's Hospital London and the Retreat at York financed by the Society of Friends.¹⁷ This movement in social care set new examples in the management and study of insanity as a discipline in its own right; the growth of a new social ideology founded in the philosophical movement of the enlightenment had brought a new sense of enquiry into all things, including the workings of the human psyche.

At St Luke's, Dr William Battie exhibited the optimism behind the new approach when he stated that:

"madness is, contrary to the opinion of some thinking persons, as manageable as many other distempers, which are equally dreadful and obstinate, and yet are not looked upon as

¹⁶ There were no records of just how many madhouses operated.

¹⁷ Guy's in 1728, St Luke's in 1751 and the Quakers hospital in York in 1796.

<http://www.jrank.org/health/pages/33461/psychiatry-%E2%80%94-history.html> Accessed 3rd December 2010.

incurable: and that such unhappy objects ought by no means to be abandoned, much less shut up in loathsome prisons as criminals or nuisances to the society”¹⁸

In practice, charitable and subscription hospitals were few in number and as a consequence, made little impact for the majority of those afflicted by madness, in short for the pauper insane, access to care was piecemeal at its best.

1.2 Hadfields's Case.

That the turn of the nineteenth century had arrived with a more enlightened approach by the medical profession to the study of madness had perhaps in part been due to the contemporary concerns over the health of King George III.¹⁹ Additionally, the attempted assassination of the King by the ‘lunatic’ Hadfield added to what was seen by many as the growing problem of criminal lunacy in the population at large. During Hadfield’s trial,²⁰ the issue of criminal behaviour attributable to mental disorder was raised in the first instance by the Attorney General Lord Mitford, who standing on precedent, stated the contemporary position as that previously surmised by Justice Tracy in Lord Onslow’s case:

"It is not every idle and frantic humour of a man that will exempt him from justice and the punishment of the law: a man must be totally deprived of his understanding and memory, and who does not know what he is doing any more than an infant, than a brute, or a wild-beast.”²¹

However, Thomas Erskine, the counsel for the defence, contested this as too narrow a perceived definition of the extent of madness, submitting that:

"if it was meant that to protect a man from punishment he must be in such a state of prostrated intellect as not to know his name, nor his condition, nor his relation towards others...then no such madness ever existed in the world.”²²

¹⁸ Battie, W. (1758) *A Treatise on Madness*, London, Whiston and White. Cited, Parry-Jones, W. (1976) *The Trade in Lunacy*, p. 93.

¹⁹ Hunter, R, & Macalpine, I, ‘The Madness of King George: A classic case of Porphyria’ *British Medical Journal*, 8 January 1966, pp. 65-71.

²⁰ State Trials 1800 v. 27, col 1312.

<http://www.webarchive.org.uk/wayback/archive/20070711230000/http://www.studymore.org.uk/mhhti m.htm>, Accessed 21 July 2011

²¹ State Trials 1724 V. 8, col 886.

<http://www.webarchive.org.uk/wayback/archive/20070711230000/http://www.studymore.org.uk/mhhti m.htm>, Accessed 21 July 2011.

After hearing the evidence from the prosecution and the opening submissions from the defence, the Chief Justice Lord Kenyon halted the trial and directed that the defendant be found not guilty through reason of insanity.²³ This however presented difficulties as to the position of the innocent man; Lord Kenyon stated that notwithstanding an acquittal following a special verdict of insanity in a defence of a charge of attempted murder, the prisoner:

"for his own sake, and that of society at large, must not be discharged: for this is a case which concerns every man of every station, from the king upon his throne to the beggar at the gate: people of both sexes and all ages may in an unfortunate hour fall a sacrifice to this man, who is not under the guidance of sound reason, and therefore it is absolutely necessary for the safety of society, that he should be properly disposed of...for the sake of the community, undoubtedly, he must somehow or other be taken care of..."²⁴

Hunter and Macalpine state that: "This verdict led to the judicial difficulty of how to dispose of him, since to release him would have been dangerous to the community as well as to himself, but no legal title existed to detain him;"²⁵ arguing that perhaps Lord Kenyon had interpreted the Vagrancy Acts as only investing powers of confinement in the offices of the local magistrates rather than his own court. This position is however at odds with the common law, where the doctrine of necessity had customarily endorsed more than sufficient precedent for the detention of dangerous lunatics. As Walker states:

"In most historical accounts of this subject ...the eighteenth century is usually dismissed in a sentence or two." "Insanity was until 1800 ineffective as a defence against a criminal charge" says one social historian: "in certain cases an individual jury might refuse to convict where the prisoner was obviously insane, but as a general rule the criminally insane went to gaols and bridewells in exactly the same way as other prisoners." This is doubly misleading. In the first place, gaols and bridewells were the places to which offenders were sent if they were found insane; it was the gallows or plantations, which awaited most of those who were not.²⁶

²² *Op.cit.* State Trials 1800 v. 27, col 1312.

²³ *Ibid.*, State Trials 1800 V. 27, col 1130.

²⁴ *Ibid.*, Lord Kenyon at col 1854.

²⁵ Hunter, R.A. & Macalpine, I. (1963), *Three Hundred Years of Psychiatry 1535-1860*. Oxford University Press, p.568.

²⁶ Walker, N, (1968), *Crime and Insanity in England: The Historical Perspective*. Vol. 1, Edinburgh University Press. p. 58.

James Hadfield's trial had started on Wednesday the twenty-sixth of June 1800. In response on the following Monday, Parliament gave leave for the first reading for a Bill for Regulating Trials for High Treason and Misprision of High Treason in certain cases, and for the Safe Custody of Insane Persons Charged with Offences. Introducing the Bill, The Attorney General Sir John Mitford stated to the house that:

"I do not particularly allude to what has previously happened; but all those whose duty calls them to attend to the proceedings of the courts of justice must think it important that some provisions should be made on this subject, because it has been found that persons who have done the most shocking acts, and who have been acquitted on the ground of being deranged in their intellects, having been allowed to go at large, have afterwards committed similar acts again: there are several instances of His Majesty's subjects who have lost their lives for want of a due provision in this respect...By the common law, when a person of this kind is acquitted, the court before which he is tried have full power to direct the safe custody of such a person: but then the law has so little regulated that custody, and is so silent as to the rules to be observed in regard to it, that it may be said to be defective in this particular and on reflection, I think that it will be impossible to lay down any positive rule, with regard to the manner of that custody, and therefore much must be left to the discretion of the executive government: but when we consider the circumstances of these unhappy persons, that generally they are of low habits and connections, and seldom have any friends to take care of them, it will appear to be humane to give to the executive government some discretion to dispose of them."²⁷

It is arguable that in recognising the distinction between mad and bad on a statutory basis, the Criminal Lunatics Act 1800²⁸ was a substantial reform in a hitherto grey area of criminal law, in providing an endorsement of insanity as a defence. However when viewed in a historical context, it is equally debateable that the Act was a punitive piece of legislation that owed more to the wishes of its political masters than any intrinsic welfare concerns over the disposal of the criminal lunatic. It is notable that the Bills' sponsors were Mr William Pitt the Prime Minister, the Hon. William Windham the Secretary at War, Sir William Grant the Solicitor General and Sir John Mitford. That such influential members of the Government of the day should have a direct involvement in

²⁷ Sir John Mitford introduced the Bill for its first reading on June 30th 1800, cited Roberts, A. <http://studymore.org.uk/1800.htm>

²⁸ The Criminal Lunatics Act 1800 (39 & 40 Geo. 3, c. 94).

what on the face of it would appear to be a minor deficiency in the legal system perhaps belies the political motivation underlying the Act.

For much of the eighteenth century, Britain had been in a continuing state of political upheaval both at home and abroad. The War of the Spanish Succession,²⁹ the Jacobite Rebellions,³⁰ the loss of the American Colonies³¹ and the War with France³² were all instrumental in contributing to a political regime that saw foreign and domestic insurgence at every turn. In Europe, the French Revolution had seen the old aristocracy swept away in the reign of terror that no doubt sent waves of anxiety through the English gentry. Furthermore, the beginnings of the Industrial Revolution had changed the nature of domestic existence from one of rural subsistence to a manufacturing centred economy³³ that relied on large pools of urban labour for its operation. However, the emergence of a capitalist economy was not without its problems; from the South Sea Bubble³⁴ to the agricultural depression of 1795, the domestic position had been one of continuing boom and bust, resulting in large-scale unemployment and poverty. The continuation of the Corn Laws³⁵ gave the English grain growers a virtual monopoly on the domestic market; prices were artificially maintained with the resulting high cost of bread in relation to wages placing a heavy burden on the general population, serving to perpetuate the economic distinction between the classes, leading to a vast increase in the number of paupers. Consequently, the resulting poverty and dissatisfaction led to increasing domestic unrest. The popular literature³⁶ of the time often, reflecting upon the evils of drunkenness and unemployment, did little to quell public fears. In government circles, fearing a fate similar to that of the *ancien regime* in France, concerns over domestic revolution increased.

²⁹ 1702-1713.

³⁰ 1715 & 1745.

³¹ 1775-1783.

³² 1795-1802.

³³ Bayliss, J. & Smith, S. (1999), *The Globalisation of World Politics: An Introduction to International Relations*, Oxford University Press. Wallerstein's World System Theory, chapter seven. Theorists argue that world politics occur within a world system dominated by the logic of capitalism.

³⁴ 1719.

³⁵ 1436 & 1463.

³⁶ For example, the series of prints by Hogarth, Gin Lane etc.

The publication of Burke's conservative political treatise *Reflections on the Revolution in France and on the proceedings in certain societies in London relative to that event*,³⁷ implied that there was more than a passing relationship between the revolutionary fervour of the mob and insanity.³⁸ That radical reform groups such as the London Corresponding Society had strong links with the Jacobin Clubs (the branches of the revolutionary movement in France) led in turn to the introduction of somewhat draconian measures by the authorities.

Between 1795 and 1800 a series of repressive measures including the suspension of *Habeas corpus* were implemented³⁹ with the intention of suppressing the radical reform and working class movements. One Act⁴⁰ made it a treasonable offence to incite the population to hatred or invoke contempt of the Crown, whilst another was listed as an Act for the more Effectively Preventing Seditious Meetings and Assemblies.⁴¹ The following years saw the introduction of Unlawful Oaths Act⁴² and a succession of measures to restrict the freedoms of newspaper proprietors,⁴³ with the final nail in the coffin of the reform movement being hammered home under the auspices of the various Combination Acts.⁴⁴

With hindsight, it is arguable that Hadfield's trial and the political furore that followed should be viewed as indicative of the political sentiments of the time. That the Pitt administration saw treason and sedition at every turn, as a consequence, it is perhaps more accurate that the Criminal Lunatics Act should be considered historically as an adjunct to an existing body of repressive legislation with social control as its underlying ideology rather than

³⁷ Burke, E. [1790], *Reflections on the Revolution in France and on the proceedings in certain societies in London relative to that event*. London. Penguin, (1982). pp. 128-145.

³⁸ *Ibid.*

³⁹ Suspension of Habeas Corpus Act was passed on 7 May 1794 and habeas corpus was suspended on 16 May 1794. The suspension lasted from May 1794 to July 1795 and again from April 1798 to March 1801.

⁴⁰ Treason Act, 1795, 36 Geo. III, c.7.

⁴¹ Seditious Meetings Act, 1795, 36 Geo. III, c. 8.

⁴² Unlawful Oaths Act, 1797, 37 Geo. III, c. 123.

⁴³ The Newspaper Publication Act, 1798, 38 Geo. III, c. 78.

⁴⁴ The Corresponding Societies Act, 1799. 39 Geo. III, c.79.

a paradigm shift in acknowledging criminal insanity in the interest's of humanitarian welfare.

Arguably with the benefit of hindsight, the position of civil unrest that characterised the late eighteenth and early part of the nineteenth centuries has many comparative parallels with the modern twenty-first century concept of "a state of emergency". Nonetheless, whichever critical interpretation is attached to the narrative, the concept of confinement introduced with the 1800 Act had and continues to be, if not entrenched, certainly instrumental in directing continuing policy in mental health law.

That the Criminal Lunatics Act is perhaps seen, as a knee-jerk reaction on the part of the government of the day is perhaps further endorsed by the lack of attention to pragmatics in the statute, as the Act had made no provisions for funding. County Justices of the Peace who were responsible for maintaining the goals found that they were liable to meet the cost of criminal lunatics, potentially for life. This was further compounded in part by the efforts of the newly optimistic medical profession in its sometimes-misguided attempts to treat madness.⁴⁵ In categorising the 'mental condition', the learned doctors had widened the net to encompass many more elements of the population as afflicted by madness. However, this in turn raised serious concerns as to what was seen as the rapid increase in the number of cases of reported insanity.

In 1807, Sir George Onesiphorus Paul noted that, '*It is an observation of medical men of extensive practice, that the lunatic affliction is a disease increasing in its influence in this country*'.⁴⁶ Further concerns on the issue of a widespread lunatic derangement of national proportions emerged when an

⁴⁵ Bewley, T. (2008), *Madness to Mental Illness: A History of the Royal College of Psychiatrists*, Published by RCPsych Publications. The prevailing belief was that madness was a result of moral weakness, leading to a moral insanity and such a diagnosis was commonplace. The only medication available was Laudanum, most treatment involved restraint and douching in ice cold baths in order to shock the patient into sensibility. Chapter 1.

⁴⁶ Report 1807 Select Committee, "to inquire into the state of the criminal and pauper lunatics in England and Wales, and the laws relating thereto." Journal of the House of Commons (39) vol 2, cited Parry-Jones, W. (1976), p.17.

article in the influential publication *The Monthly Magazine* stated, 'Madness, strides like a Colossus in the country'.⁴⁷

As a consequence of such alarmist notions, many of the county jails housed more lunatics than the local madhouses, a position that imposed unwanted burdens on the county purse and a great deal of discord between the Aldermen of the boroughs and the Officers of the County; a situation so *in extremis* that resulted in Parliament inviting a Select Committee to consider the legal repercussions of the Criminal Lunatics Act in relation to the use and practice of the Vagrancy Acts.

The Committee found that though under the Vagrancy Acts, parish officers were liable for controlling lunatics and had to find the costs for confinement from parish rates, the Criminal Lunatics Act had given them the opportunity to lay the costs at the county's door.

Sir Paul argued that under the new Act, parish officers were by way of circumnavigation, able to:

"encourage, rather than prevent an outrage that may bring a man to trial and thus effect this important saving to the funds of his parish".⁴⁸

As a result, the Committee recommended that there should be proposals for a co-ordinated approach by central government, county and parish authorities to establish institutions for the insane, with the intention of addressing the increasing problem of overcrowding in both the workhouses and the county jails.

The Committee's proposals became law with the assent of the County Asylums Act 1808.⁴⁹

⁴⁷ Reid, J. (1808), 'Report of Diseases' *The Monthly Magazine* 25, p. 166, cited Parry-Jones, W. (1976) p. 11.

⁴⁸ Report 1807 Select Committee, cited Parry-Jones, W. L. (1976) p.17.

⁴⁹ County Asylums Act 1808, George 3, c.96. An Act for the better Care and Maintenance of Lunatics, being Paupers or Criminals. County JPs were given powers to construct asylums.

The opening preamble of the Act read as follows:

'Whereas the practice of confining such Lunatics and other insane persons as are chargeable to their respective parishes in Gaols, Houses of Correction, Poor-houses, and Houses of Industry, is highly dangerous and inconvenient, and whereas it is expedient that provision should be made for the care and maintenance of such persons, and for the erecting of proper houses for their reception ... it shall be lawful for the Justices, assembled in Quarter Sessions of the County, to take into consideration the expediency of providing a Lunatic Asylum in such County.'⁵⁰

Under the Act, magistrates were allowed to build rate-supported local asylums. However, the Act was largely ineffective since anyone could obtain a license and open an asylum.⁵¹ Nevertheless, the reforms begun by the County Asylums Act, initiated the era of the public asylum system.

1.3 The Great Confinement: The rise and fall of the asylums

That central government should act in respect of what was seen as the increasing problem of public lunacy by adopting an institutional position was a result of several contributing factors. The period of the Enlightenment during the eighteenth and early nineteenth centuries saw a new and continuing optimism on the part of the medical profession's interest in hospital care and treatment of the insane, with public asylums providing easy access to new patients, and the costs being met by the public purse.⁵² Secondly, as reforming principles of social morality⁵³ and identity provided a certain justification for treating the insane as a separate class (as opposed to criminals) warranting special treatment, this distinction itself provided a measure of legitimacy for the necessity of confinement. In addition, there was the institutional effect of the poor law system itself as an appropriate mechanism for economic and social control. Workhouses (which were paid for out of parish funds) were over-crowded and the admission of pauper lunatics

⁵⁰ Bewley, T. (2008), *Madness to Mental Illness: A History of the Royal College of Psychiatrists*, Published by RCPsych Publications. p. 6.

⁵¹ Parry-Jones, W. L. (1976), Chapter 2.

⁵² *Op. cit.* County JPs were given powers to construct asylums under the County Asylums Act 1808.

⁵³ Notably Bentham and Mill

to such places was increasingly viewed as inappropriate by reformers. Thus the conception of the public asylum system was as much about economic dependency and collective social control as it was about the humanitarian treatment of lunatics.⁵⁴ In terms of infrastructure, the continuing lack of a unitary approach resulted in piecemeal organisation through local government that continued to a greater or lesser degree throughout the country.

Following the regulation imposed by the Madhouse Act (1774) in the last quarter of the eighteenth century, there were reportedly at various times between sixteen and twenty-two metropolitan and provincial licensed madhouses.⁵⁵ By 1807, the Select Committee recorded that there were only forty-five licensed institutions in England and Wales. The County Asylum Act (1808) provided the impetus for the construction of public asylums on a larger scale. This was followed by a requirement in the 1828 Madhouse Act that all asylums and private institutions would be obliged to employ a permanent medical officer. However the debate between the parishes, counties and central government continued with the publication of the 1844 Report of the *Metropolitan Commissioners in Lunacy to the Lord Chancellor*,⁵⁶ which only served to accentuate the disparity between what Parliament intended and the civic purse provided.

In 1845, the Lunatics Act was introduced, which made county asylum provision mandatory under the auspices of a national system of inspection of standards, administered by the Lunacy Commission. For the first time, central government legislation allowed for the construction of asylums for the relief of the insane poor out of county funds. Local committees of Justices of the Peace oversaw such institutions, with admission made by an order of the

⁵⁴ Parry-Jones, W. L. (1988), 'Asylum for the Mentally Ill in a Historical Perspective.' *Psychiatric Bulletin* 1988, 12: 407-410. The exclusion and incarceration of the insane in the 17th century has been viewed by some historians as a politically expedient way of establishing social order and the protection of society. p. 408.

⁵⁵ Parry-Jones, W. L. (1972) p. 30. Makes the comment that though figures can be extrapolated from the Treasurers records of The R.C.P. and the Country Register, they are at best approximate.

⁵⁶ Cooper, A. the Earl of Shaftesbury, (1801-1885). *The Report of the Metropolitan Commissioners in Lunacy to the Lord Chancellor*, July 1844.

<http://www.webarchive.org.uk/wayback/archive/20070711230000/http://www.studymore.org.uk/mhhti m.htm>

justice supported by one medical certificate, and usually signed by the poor law relief medical officer. However, disposal of the “criminally insane” remained for the most part within the offices of the county asylums until the Criminal Lunatics Act of 1860 and the opening of the Broadmoor asylum in 1863.

The continuing debate on humanitarian treatment led to the setting up of the Select Committee of the House of Commons appointed 12th of February 1877 under the chairmanship of Thomas Dillwyn:

"to inquire into the operations of Lunacy Law so far as regards security afforded by it against violations of personal liberty".⁵⁷

The Committee's findings along with a report of the raised several issues that were eventually put before parliament as the Lunacy Acts Amendment Bill 1888⁵⁸ including consolidating clauses that introduced further judicial authority for ordering the detention of a person of unsound mind as a lunatic. It also provided that all orders of detention should cease to have effect unless renewed at the stated time and put restrictions on the opening of new private asylums.

Though the Bill fell in the upper house, it laid what were to become the foundations of the legislative regulation and protection of powers of detention under the Mental Health Act. Thus in the establishment of public funded asylums, professional medical advancement, humanitarian concerns and the economic and political aims of the state, all gained a degree of substance under statute.

⁵⁷ SCHC, (1877-1878): Reports from the Select Committee of the House of Commons appointed 12.2.1877 under the chairmanship of Thomas Dillwyn *"to inquire into the operations of Lunacy Law so far as regards security afforded by it against violations of personal liberty"*. p.17 <http://www.webarchive.org.uk/wayback/archive/20070711230000/http://www.studymore.org.uk/mhhtm.htm> Accessed 12th January 2011.

⁵⁸ The Bill was withdrawn by common agreement in July and was re-introduced as the Lunatics Law Amendment Act 1889, Royal Assent 26. 8. 1889.

Nonetheless, until the introduction of the Lunacy Act in 1890, the administration of public mental health law (as opposed to private institutions) had remained largely within the province of various County Asylum Acts. The Lunacy Act (1890) was perhaps a reflection of the changing philanthropy that imbued all aspects of the late nineteenth century Victorian society.⁵⁹ It is perhaps by today's standards recognised as a paradigm shift in combining the various strands of legislative threads both private and public that related to the laws relating to the care of insanity, into one statute, which remained substantively in force until the 1930's.

The introduction of the Mental Deficiency Acts, the first in 1913, further consolidated the plight of the mentally disordered, moving 'imbeciles and idiots' away from the care of the Commissioners of Lunacy to local authorities, requiring that:

'...all County and County Borough Councils to establish a Mental Deficiency Committee for ascertaining all the people in the area needing to be dealt with, providing and maintaining suitable institutions, providing care for mental defectives in the community, (s 27-33).'

In doing so, it not only laid the foundations for the current system of guardianship (*parens patriae*) - albeit under the auspices of the common law - but also took the first steps towards care in the community.

Thus far there had been little statutory or for that matter medical distinction between 'idiots' and 'lunatics'; the earlier Idiots Act of 1886 approached the distinct nature of developmental disability, but for the most part in practice, until the Mental Deficiency Acts, the treatment of mental deficiency (mental disability) and mental disorder had been confined to the same institutions.

The first half of the twentieth century also saw the opening of the Maudsley Hospital (1923), which was the first psychiatric facility to be opened to informal patients to provide treatment for disorders not severe enough to require formal

⁵⁹ Including legislation such as the Elementary Education Act (Blind and Deaf Children) 1893 & the School Attendance Act.

admission.⁶⁰ The introduction of the Mental Treatment Act (1930), introduced set procedures for formal and informal admissions. In terms of a legal appreciation of individual autonomy, the Act introduced the modern concept of voluntary and informal admission. From 1930, it became possible to be admitted to a psychiatric facility without a formal binding order. Prior to the Act, there had been no statutory distinction between admission and confinement.

The 1930s also saw a change in attitudes towards community care policy; new objectives were brought about as much by the social development of state welfare provisions as by changing medical opinion on how treatment should be delivered. The expansion of an ideology of a proactive welfare state providing both financial benefits and services created a new presumption that care outside mental institutions was not only financially feasible but also more socially acceptable. Such new directions in policy effectively swept away the remnants of the old poor law, replacing it with welfare provisions based on insurance principles.⁶¹

1.4 The Welfare State

The implementations of the post-war socialist ideology that saw the birth of the National Health Service⁶² also saw a change in policy and practice; the development of the modern welfare state with the introduction of a social welfare benefits system to provide financial assistance. This meant that it was no longer necessary to remove impoverished patients into the old county asylums, in effect, sweeping away the last vestiges of the old 'poor laws'.

The growth of public social housing and the improvements in access to primary care now meant that many patients could be treated without the need for incarceration. The NHS inherited a large number of municipal, charitable

⁶⁰ The Lunacy Act 1890, section 11, Urgency orders. In cases of urgency where it is expedient, either for the welfare of a person (not a pauper) alleged to be a lunatic, or for the public safety,

⁶¹ Busfield, J. (1986) *Managing Madness: Changing Ideas and Practice*, London, Unwin Hyman. pp. 358-370.

⁶² National Health Service Act 1946 came into force 5th July 1948.

and mental hospitals, including the remnants of the old 'work house wards,' all of which were nationalised under the legislative provisions of the 1946 NHS Act, making the distinction between private and public facilities largely irrelevant. This now meant that in theory, the consolidated mental health services would operate under the same conditions as other branches of the NHS. However, in practice, mental health services were still governed by an archaic and cumbersome body of law.⁶³

By the 1950s, Britain had emerged from a period of austerity, there was a post war employment boom, and the general climate had become more liberal with a broader range of citizenship rights defined by the European Convention on Human Rights.⁶⁴ The post-colonialism of the political world stage was reflected in new key concepts of human dignity, equality and anti-discrimination. Newly emerging International organisations such as the World Health Organisation and the World Federation of Mental Health vigorously promoted reforming psychiatric care. Subjectively, other factors were influential in accelerating the reform process. It was generally accepted that asylums did not cure patients,⁶⁵ there had been a pharmaceutical revolution in the development of new anti-psychotics⁶⁶ allowing more flexibility for treatment in the community, and there was a more tolerant attitude in general towards the mentally ill.

A new Mental Health Act⁶⁷ based on proposals by the Percy Commission, concluded that:

... that the law should be altered so that whenever possible suitable care may be provided for mentally disordered patients with no more restriction of liberty or legal formality than is applied to people who need care because of other types of illness, disability or social difficulty”⁶⁸

⁶³ The Lunacy Act 1890, The Mental Treatment Act and the Mental Deficiency Acts were not appealed until the Mental Health Act 1959.

⁶⁴ Council of Europe, though not ratified by the UK until 1951.

⁶⁵ http://www.mind.org.uk/help/research_and_policy/the_history_of_mental_health_and_community_care-key_dates. After rising steadily throughout the first half of the century, the resident population of psychiatric hospital beds reached a peak of 152,000 in 1954/55. Many of the hospitals were extremely overcrowded; for example, Friern Barnet hospital was built in 1851 to accommodate 1000 patients but by 1950 it accommodated over 2000. Insulin dependant coma was widely used to sedate patients.

⁶⁶ Notably Chlorpromazine, marketed by Smith Kline French.

⁶⁷ The Mental Health Act 1959, Royal Assent 29.7.1959.

The new MHA Act into force in 1959, it adopted what many saw as a more humane and enlightened approach towards the treatment of the mentally ill; recognising that mental illness was an illness that required medical intervention just the same as any physical ailment.⁶⁹ The intent of the 1959 Act was “to repeal the Lunacy Act 1890, the Mental Treatments Act 1930 and the Mental Deficiency Acts, 1913 to 1938 and to make fresh provision with respect to the treatment of mentally disordered persons with respect to their property and affairs”.⁷⁰ ‘In endorsing a ‘medical model’ the 1959 Act invested the medical profession with considerable powers in making decisions about initial admissions, subsequent detentions and treatment, whereas previously, commitment was a matter for the courts⁷¹ and hospital administrators (Medical Superintendents).

On a positive note, the introduction of Mental Health Review Tribunals provided a mechanism whereby a patient could challenge the circumstances of his Confinement. It made guardianship (*parens patriae*)⁷² a statutory process where before it had fallen for the most part to the common law.⁷³ The Act also made provisions for local authorities to provide services for those patients that did not, or no longer required in-patient care, and although this was not a mandatory requirement, it did provide a positive move towards care in the community.

On a less positive note, the abolition of the Mental Deficiency Acts placed individuals with developmental impairment squarely within the remit of the MHA 1959. The result is one that would seem to disadvantage people with developmental disabilities by treating them objectively as mentally ill. Consolidating the statute meant that any legislative opportunity to specifically

⁶⁸ *Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency. 1954-1957*. Chairperson: Lord Percy. Cmnd 169. (1957), London, HMSO. Para 7.

⁶⁹ *Royal Commission on the Law Relating to Mental Illness and Mental Deficiency* (1957), Cmd. 169 para 5: ‘disorders of the mind are illnesses that require medical treatment’.

⁷⁰ The 1959 Mental Health Act.

⁷¹ Judicial commitment was abolished by the MHA 1959.

⁷² “Parent of the Country.”

⁷³ The 1913 Mental Deficiency Act, Under Part 1, s.3. Guardians had very broad and ill defined powers based on the common law doctrine of *parens patriae*. Part IV sections 33 & 34 of the 1959 MHA imposed limitations on the powers of guardians.

address the needs of what amounted to a minority group (developmental disabilities), had for the main part disappeared. Should people with developmental disabilities be subjected to a body of law that was primarily intended to address mental illness, when they were not actually mentally ill in a conventional sense? A position, that continued under the 1983 Act and has remained contentious until the present day. Nonetheless, the 1959 Act implemented a robust unitary mental health regime founded in statute and introduced community care principles that allowed patients a greater degree of participation in how they should be treated.

In principle, the policy shift towards community care should have cleared the way for improvements in civil and political rights (CP rights) and social, economic and cultural rights (SEC rights) in the management of mental illness, however, in practice, the continuing endorsement of medical paternalism in the 1959 Act, coupled with low investment in non-medical social care only served to maintain mental health treatment as a poor 'Cinderella service' with much of its resource tied up in the old asylum system.⁷⁴ In addition, the European Convention on Human Rights (ECHR) although in principle, guaranteed the right to individual liberty and security, it also sanctioned the denial of rights of the mentally ill:

Article 5, the 'Right to liberty and security' allows for:

'...the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts, or vagrants'⁷⁵

However, government interference in convention rights must be no more than is 'necessary' (proportional), and adopt the least restrictive approach and is further qualified by the ability to challenge any interference (in this case detention).⁷⁶ Nonetheless, the growth of populist human rights meant that

⁷⁴ *Op. cit.* Many of the old mental hospitals were overcrowded and understaffed. Friern Barnet hospital was built in 1851 to accommodate 1000 patients but by 1950 it accommodated over 2000.

⁷⁵ Article 5, s1, ss, (e).

⁷⁶ Paragraph a of Article 5 para 4 (art. 5-4) provides that: "Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful."

many organisations lobbied to extend the notion of CP rights to people with mental illness. Widespread campaigns by social movements, notably the National Council for Civil Liberties (NCCL)⁷⁷ and the Socialist Health Association pressed for the closure of the old asylums and the release of what they saw as patients who had been wrongly incarcerated in mental institutions.

In 1961, Enoch Powell, the then Secretary of State for Health, in his famous 'Watertower'⁷⁸ speech predicted the closure of the older Victorian style institutions within fifteen years. At Conference he proposed the framework that became the 1962 *Hospital Plan for England and Wales*,⁷⁹ whereby a controversial large-scale reduction in mental health beds was planned and in their place, small psychiatric units would operate in the community, with local authorities responsible for a new framework providing after care and home support by recruiting more social workers. A year later, the conservative government produced *Health and Welfare, The Development of Community Care*,⁸⁰ these policy documents effectively set the scene for future government policy, in that they created the framework that resulted in a separation of general hospital facilities and community agencies.

The reorganisation of welfare services by the consolidation of social work into the new local authority social services departments moved psychiatric social workers from their role in general hospitals to the more general role of the 'new' Approved Social Worker as part of the establishment of a community psychiatric nursing service. However, due to concerns over funding several critics warned that community care would fail if lack of investment resorted in inadequate resources.⁸¹

⁷⁷ Now Liberty.

⁷⁸ At the Conservative Party Conference Blackpool 1961. Discussed in Chapter 2, 'New Services for Old, Beyond the Water Towers, SCMH London.

⁷⁹ MOH 1962. *A Hospital Plan for England and Wales*, London, HMSO.

⁸⁰ Ministry of Health 1963. London, HMSO.

⁸¹ Titmuss, R. (1961) Fact or Fiction? Conference report, National Association for Mental Health, cited in Beyond the Water Towers, SCMH London, p.29.

The transition between hospital care and community services was not without its problems. In 1971, the government produced a statement of policy, *Hospital Services for the Mentally ill III*⁸², which acknowledged the importance of non-hospital facilities in the process of closing the old large mental hospitals. After years of political infighting, it was announced that local health authorities and not local government would administer the NHS,⁸³ with local government funding the secondary supporting services with additional cash in the form of supplementary benefits from a central government fund. This was followed in 1975 by the White Paper, *Better Services for the Mentally Ill*⁸⁴ that set out four key objectives:

- i. Expansion of local authority residential, day care and social work support services;
- ii. Relocation of specialist services in local settings;
- iii. Establishment of the correct organisational links between day and residential care services, between specialist teams and primary care services, between local authority administrators and planners and between professionals and non-professionals;
- iv. Staffing improvements that would make assessment, review, early intervention, and preventative work possible.

The White Paper emphasised that the suggested guidelines were tentative and that:

“...even in favourable economic circumstances it would obviously take a long term programme to achieve in all parts of the country the kind of change we are advocating...even within a twenty-five year planning horizon...discharge from a hospital into the community which lacks hospital facilities...may well be a change for the worse..”⁸⁵

Therefore, in terms of service provision, the growth of community care and the accompanying expectation of participatory CP rights were slow at best. Accordingly, the anticipated closure of the old Victorian institutions and the

⁸² *Hospital Services for the Mentally ill III*, DHSS 1971 HMSO London.

⁸³ Department of Health and Social Security (1972) *White paper on National Health Service Reorganisation*. London, HMSO.

⁸⁴ DHSS 1975, London, HMSO.

⁸⁵ Cited, “*Beyond the Water Towers*,” London, SCMH, p.30.

move from segregation to community citizenship was held back by the disconnected provision of services.

In 1979, the European Court, following an application from a formally detained Dutch citizen, set a landmark ruling in the case of *Winterwerp v the Netherlands*.⁸⁶ The judgement, upheld that there had been a breach of Article 5 para. 4 (art. 5-4) but not of Article 5 para. 1 (art. 5-1),⁸⁷ setting out certain safeguards regarding the circumstances under which deprivation of liberty is justified.

- i. that a true mental disorder has to be established by medical expertise.
- ii. that the mental disorder is of a kind or degree warranting compulsory confinement; and
- iii. the validity of continued confinement depends on the persistence of disorder.

These are now known as the '*Winterwerp criteria*' which are still the cornerstone of human rights in mental health and the Human Rights Act 1998. The implication of the ruling is that it effectively endorses the psychiatric discretion of the 'medical model', thus, any future challenge would have to consider abuse of due process rather than substantive treatment as grounds for appeal.⁸⁸

In 1981, with the support of Mind, the case of *X v the United Kingdom*⁸⁹ was laid before the European Court. While the substantive reasons were seen as meeting the *Winterwerp criteria*, the European Court of Human Rights found that the procedure by which X's long-term confinement was sustained did not. Accordingly, the Court found the UK to be in breach of Article 5(4)⁹⁰ because

⁸⁶ *Winterwerp v the Netherlands*, (1979) 2 EHRR 387.

⁸⁷ *Ibid.*, At para 34 of the judgement.

⁸⁸ Fennel, P. (1996), *Treatment without Consent: Law, Psychiatry and the Treatment of Mentally Disordered People since 1845*, London & New York, Routledge. pp. 106-111.

⁸⁹ *X v the United Kingdom* (1981) 4 EHRR 181. X had been conditionally discharged from a mental hospital but recalled on the order of the Home Secretary under the 1959 MHA.

⁹⁰ ECHR Article 5(4); Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

the final decision regarding the discharge of restricted patients rested solely with the Home Secretary, with no provision for his or her decision to be reviewed by a court.

That there had been a number of decisions by the European Court in Strasbourg coupled with considerable pressure from service user groups and the media following a number of abuse scandals within the old asylums, provided the necessary impetus for a review of the existing legislation, the result being the 1983 MHA, which consolidated the 1959 MHA and the 1982 Mental Health (Amendment) Act.

Rather than creating any fundamental change in policy direction, the 1983 Act tidied up some of the loose ends that had proved problematic in the previous legislation. It did however introduce a number of important changes; the ruling in *Winterwerp* undoubtedly influenced the core elements of the ‘*treatability test*’, which stated that a patient with a psychopathic disorder could only be compulsorily admitted to ‘alleviate or prevent deterioration in their condition’.⁹¹ Certain treatments, if to be given under compulsion, would require the agreement of a Second Opinion Appointed Doctor (SOAD)⁹² and significantly, following *X v the United Kingdom*,⁹³ the new Act gave patients the right to more frequent access to MHRT’s and tribunals the power to decide rather than advise the Home Secretary on release.⁹⁴ By doing so, the MHA1983 did in fact provide a considerable improvement in defining through statute certain aspects of CP rights that previously had been within the remit of medical paternalism on the basis of ‘best interests’.

While on the one hand, some improvements to CP rights were now a matter of statutory regulation, on the other, apart from the right to aftercare in s117, any advance in access to services and the accompanying SEC rights remained for the most part, outside the scope of the legislation. The Mental

⁹¹ MHA 1983 s1(2).

⁹² MHA 1983 Part IV procedures operated by the MHAC.

⁹³ *X v the United Kingdom* (1981) 4 EHRR 181.

⁹⁴ MHA 1983 s.65, Sch. 2 & the MHRT rules 1983, SI 1983/942. Though this may not apply if a criminal court has ordered that the defendant be detained in hospital subject to s.37 of the 1883 Act. If restrictions are imposed, the Secretary of State has considerable latitude over tribunal decisions.

Health Act Commission was also established to protect the rights of detained patients and the procedural obligations imposed by s118.⁹⁵

However, the very large number of policy documents, revised codes of practice and directives emanating from the Department of Health since 1983, providing for many aspects of psychiatric care, has resulted in an increasing reliance on extra-legal regulation. No doubt the process of administrative audits and similar protocols, as a method of enforcement is sound in principle, but in practice, they are often difficult to navigate through the sheer volume of bureaucracy. Much of the guidance material is of course supplementary to the legislation itself, though for the most part it remains either a matter of medical discretion regarding 'best interests' or subject to interpretation by the courts.⁹⁶

Nonetheless, the shift towards care in the community continued with the closure of the old asylum regime, with the majority of inpatient admissions being short term in specialist psychiatric wards in general hospitals rather than mental hospitals.⁹⁷ The 1975 White Paper (as above) had begun to change the boundaries, emphasising the policy first outlined by Enoch Powell, that the appropriate care for chronic mental illness was to be small-scale mental health community based units, funded by local authorities. The Care Program Approach was introduced in England and Wales in a joint Health and Social Services Circular, which required:

'...that Health Authorities, in collaboration with Social Services Departments, were to put in place specified arrangements for the care and treatment of mentally ill people in the community.'⁹⁸

⁹⁵ A Special Health Authority established by s. 121 Mental Health Act 1983 (c. 20) under s. 11 National Health Service Act 1977 (c. 49).

⁹⁶ For example; the ability for one party to make substituted decisions regarding incapacitated consent to treatment, *F v West Berkshire HA* [1989] 2 All ER 545.

⁹⁷ Barnham, P. (1992) *Closing the Asylum: The Mental Patient in Modern Society*, London: Penguin p. 20.

⁹⁸ HC, (90) 23/LASSL(90)11'15 16. 'The Care Programme Approach for people with a mental illness, referred to specialist psychiatric services' published by the Department of Health in 1990, effective from 1 April 1991. There were some differences to the application of CPA in Scotland, which was effective from 30 April 1997, and in Wales, but the principles are the same. <http://cpaa.co.uk/thecareprogrammeapproach> Accessed, 24th May 2011.

However, as Ryan *et. al.*⁹⁹ note: the care program did not happen overnight. Its origins can be traced back to at least the 1985 Social Services Committee Report,¹⁰⁰ which states:

‘Nobody should be discharged from hospital without a practical individual care plan jointly devised by all concerned, communicated to all responsible for its implementation, and with a mechanism for monitoring its implementation or its modification in the light of changing conditions; and *that the resources for this be made available*’

In 1987 the Mental Health Act Commission first applied this concept to patients subject to aftercare under the Mental Health Act 1983¹⁰¹:

‘After-care plans for patients to whom Section 117 applies should be drawn up on a multidisciplinary basis as soon as possible after the patient is admitted, and liaison should take place prior to discharge between workers from the community and the hospital team...’¹⁰²

However, it was not until a report by Sir Roy Griffiths; *Community Care: Agenda for Action. A report for the Secretary of State for Social Services*¹⁰³, that followed an Audit Commission report (1986) that the real nature of the crisis emerged. Although the old hospitals were slowly transferring patients into community settings, community services were not adequately funded to provide the care required. The Griffiths’ Report proposed the transfer of all community care into the hands of local authorities. The Government response took the form of a White Paper,¹⁰⁴ that proposed a new framework for

⁹⁹ Ryan, P., Ford, R., Clifford P. (1991) *Case Management and Community Care: An examination of the place of case management in the new policy initiatives of the care programme approach and care management*. Research and Development for Psychiatry, London, SCMh, p. 25.

¹⁰⁰ Second Report from the Social Services Committee Session 1984-5. *Community care: with special reference to adult mentally ill and mentally handicapped people*. Volumes I, II and III. London: HMSO, 1985. Executive Summary.

¹⁰¹ Mental Health Act 1983 (c. 20) at s. 117, which applies to people detained under: s. 3 (Admission for treatment), s. 37 (Hospital Order), s. 47 (Transfer of a sentenced prisoner from prison to hospital), s. 48 (Transfer of an unsentenced prisoner from prison to hospital).

¹⁰² The Mental Health Act Commission Second Biennial Report, 1985-1987, HMSO, October 1987 at p. 66 (Ch. 21, recommendation 14. (i)).

¹⁰³ Griffiths, Sir R. (1988) *Community Care: Agenda for Action. A report for the Secretary of State for Social Services*, London HMSO.

¹⁰⁴ *Caring for People*, (1989), DHSS, London HMSO.

changes to the community care system, that were later implemented by the National Health Service and Community Care Act, 1990.

Subsequently, the relationship between medical care and the cost of care in the community was more clearly defined by statute. The Act stipulated that the planning of services, assessments, and provision would be the overall responsibility of local authorities social services departments (SSD's), working in co-operation with other stake-holders,¹⁰⁵ with nursing care the responsibility of health authorities (now PCT's).

The NHSCCA aimed for a system of care that was intended to be more user driven as opposed to fitting the client into existing services and:

'ensure that a seamless community care service is available which covers both health and social needs'.¹⁰⁶

Though the Act itself did not define 'community care' *per se*, 'community care services' were defined by s. 46(3) to comprise those, which may be provided under:

- a) Pts III of the National Assistance Act, 1948;
- b) s. 45 of the Health Services and Public Health Act, 1968;
- c) s. 21 and Sch. 8 of the National Health Service Act, 1977;
- d) s. 117 of the Mental Health Act 1983.

Subject to assessment under s.47.¹⁰⁷ It should be noted that the Act was to be applicable to all patients in a community setting, not just the mentally disordered.

By bringing together several different strands of existing legislation, it was intended that the amendments would provide easier access to

¹⁰⁵ NHSCCA 1990 s.46(1) (a) Requires every SSD to publish and retain under s.46(1) (b) review, a plan for the provision of community care in its area. , Now supplemented by the Health and Social Care Act 2001; Ch 2, Pts 3 & 4.

¹⁰⁶ Baroness Blatch, *Hansard*, HL, vol. 518, cols 1537-8.

¹⁰⁷ s. 47 did not come into force until 1st April 1993.

accommodation services, welfare services, health services and aftercare suited to a wider group of clients on a bespoke basis, with particular emphasis for the elderly patient.

The new framework was not without its problems. It was soon apparent that there were a number of grey areas mostly concerned with provision (*sic* funding) that fell between what amounted to social care and what was clearly health care, i.e. nursing care provided in a residential setting. As a consequence, many contentious cases were, as a matter of course referred to the courts for adjudication - for example, *Avon County Council v Hooper and another*,¹⁰⁸ essentially a disagreement between the local Social Services Department (LSSD), Health Authority and the deceased's estate as to the costs of care in H's lifetime. There are of course many more cases in the same vein and subsequent pieces of legislation¹⁰⁹ relating to care provision that are too numerous to discuss within the central theme of this chapter.

The Act also introduced the Care Plan Approach (CPA) on a statutory basis that aimed:

'to ensure the support of the mentally ill persons in the community thereby minimising the possibility of their losing contact with services and maximising the effect of any therapeutic intervention.'¹¹⁰

This shift in policy had two far-reaching effects for the mentally ill; firstly, by robustly moving towards providing care in the community, mental illness in the community was now within the remit of SSD's and therefore a community issue as much as a medical one, including a wider responsibility, that community care provision now entailed local government economic efficiency based on free market concepts with stake-holders designated as either providers or purchasers, including wider private sector participation. Secondly, Approved social workers now had a more clearly defined function in mental

¹⁰⁸ *Avon County Council v Hooper and another*, [1997] 1 All ER 532 (CA).

¹⁰⁹ For example, Housing Act 1996 & Community Care (Direct Payments) Act 1996.

¹¹⁰ DOH (1994), para. 9.

health, expanding on the role created under the MHA 1983, s. 114, (2),¹¹¹ with many approved social workers taking on the responsibilities of nominated key workers in mental health teams in the community.

In terms of rights, it is arguable that on one side the investment in policy in moving towards a community based care service was seen as a positive move towards further gains in SEC rights. However, the earlier misgivings voiced by the Audit Commission (1986) and the Griffiths' Report echoed the same sentiments¹¹² that had preceded the first steps towards community care following the implementation of the 1959 Act. In short, any advancement in SEC rights through community care, would always be subject to budgetary considerations.

Almost immediately following the implementation of the NHSCCA, two incidents occurred that shifted policy focus. On the 17th December 1992 Christopher Clunis fatally stabbed Jonathan Zito in the eye at Finsbury Park tube station. Clunis, a young black Afro-Caribbean man diagnosed as having schizophrenia, had recently been released from Guys' hospital into the community. That such a random killing had occurred in a public (safe) place, created a great deal of furore in the media with headlines such as: "Tube Man Dies in Knife Attack"¹¹³ ... "Knife Death Terror at Tube Station"¹¹⁴

Shortly after, on the 31st of December 1992 Ben Silcock, a 27-year old man also suffering from schizophrenia, climbed into the lion's den at London Zoo where he was mauled by a lion. The incident made the pages of the national press, with comments such as: 'Care in the community: Ben Silcock's mauling by a lion at London Zoo has highlighted the plight of the mentally ill.'¹¹⁵

¹¹¹ Approved Social Workers must be 'of appropriate competence in dealing with persons who are suffering from a mental disorder'.

¹¹² Titmuss, R. (1961) Fact or Fiction? Conservative Party Conference report, National Association for Mental Health, *cited in* Beyond the Water Towers, SCMH London, pp. 29-30.

¹¹³ *The Daily Mirror* 18.12.92.

¹¹⁴ *The Daily Mail* 18.12.92.

¹¹⁵ *The Independent*, 12.01.93.

Both incidents served to highlight growing public concerns in the media over the use of community care as a viable option for discharging patients from hospital. The move towards long-term community care¹¹⁶ had unintentionally created a number of additional problems. Within the old asylum system, incidents of abuse, violence and administrative failure had for the most part remained behind closed doors and more significantly, unknown to the general public.¹¹⁷ Incidents such as the murder of Jonathan Zito by Christopher Clunis,¹¹⁸ the Ben Silcock affair and more recently the case of Michael Stone,¹¹⁹ all served to epitomise the fear of the *deranged madman* at large in the community.

The increasing public awareness of such incidents contributed towards a notion of dangerousness, that had for the most part had previously been one of *urban mythology* but was now becoming manifest as one of the central driving forces for legislative reform, at least in the eyes of the general public. Furthermore, the public inquiries that followed such incidents tended to expose community aftercare as at best ineffective and at worst irresponsible

Whereas from the early 1980's, policy for the most part had been focused in the 'language of rights', the impact of the Clunis and Silcock affairs changed the general discourse to one of '*risk and coercion, coupled with dangerousness*'. The result was an Act to amend the existing legislation with the Mental Health (Patients in the Community) Act 1995,¹²⁰ in England and Wales:

"An Act to make provision for certain mentally disordered patients in England and Wales...to amend the law relating to mentally disordered patients absent without leave...or on leave of absence from hospital; and for connected purposes."

¹¹⁶ First begun with the closure of the old asylum system.

¹¹⁷ With the occasional exceptions such as the The Whittingham Hospital Report, Cmnd. 4861 (February 1972).

¹¹⁸ Clunis killed Jonathan Zito at Finsbury Park Tube Station in an apparently random attack on

¹¹⁹ These incidents are discussed in depth in Chapter three.

¹²⁰ Royal assent 8th November 1995.

The Act also provided for the making of Community Care Orders (compulsory) in the case of certain mentally disordered patients in Scotland. In England and Wales, the Act provided for Aftercare Under Supervision Orders (ACUS's), which were intended to bolster the powers of Health Authorities (PCT's) and Social

Services Departments's (SSD's) in providing aftercare post s.117. As above, SSD's and other stake-holders would be required to appoint a care manager whose responsibility would be to see that the required services could be provided for a patient in the community. On a positive note the provisions of the Act¹²¹ enabled discharged patients access to a wider range of joined-up services. In addition, it is a requirement that all parties, including the patient are part of the supervision application process,¹²² though it should of course be realised that under s.117 discharge, an ACUS order in reality should be seen as an extension of hospital treatment, rather than an alternative to hospitalisation as is the case with a guardianship order (a more traditional though less often used form of care in the community).

1.5 New Labour, the third way

When New Labour came to power in November 1997 with a landslide majority, it had, in its manifesto, pledged to reform the NHS, Predictably, in view of the Clunis/Zito and Silcock debacles, that pledge included mental health services. The government published a policy document; *Modernising Mental Health Services*,¹²³ 'dubbed' 'the Third Way'. In the foreword, Frank Dobson, the then Secretary of State for Health, outlined several proposals including the following:

"The law on mental health is based on the needs and therapies of a bygone age. Its revision in 1983 merely tinkered with the problem. What I want now is root and branch review to reflect the opportunities and limits of modern

¹²¹ s. 25A-25J,

¹²² s. 25 B, ss2 (a) (i).

¹²³ Department of Health, *Modernising Mental Health Services: safe, sound and supportive*. (1998) DOH.

therapies and drugs..."It will cover such possible measures as compliance orders and community treatment orders to provide a prompt and effective legal basis to ensure that patients get supervised care if they do not take their medication or if their condition deteriorates.¹²⁴

Dobson's comments at the time, strongly suggested that future reforms would include compulsory treatment in the community. However, such reforms proved difficult in practice. Considering Frank Dobson's statement that the *Modernising Mental Health* policy document (as above) advocated; 'safe, sound and supportive' services, in terms of advancing rights, the policy can be viewed in both a positive and negative context. Positive in providing 'safe, sound and supportive' services, negative in the possibility of enforcing additional restrictions for patients in the community in the interests of public safety.

There are undoubtedly a number of contradictory issues involved in shaping mental health policy, contextually, to what extent has the HRA acted as a catalyst for change? In positive terms, the HRA has made it easier to press cases in the domestic courts, still relying on the 'Winterwerp criteria', which prior to 1998 were for the most part interpreted restrictively. However in the case of *R (Wilkinson) v RMO Broadmoor Hospital*,¹²⁵ which concerned forcible treatment, the Court of Appeal decided that it had the right to hear evidence on the basis of Articles 3 and 8,¹²⁶ suggesting that judicial reasoning was moving from procedural analysis to a more subjective stance.

Significantly, article 5.(4) has been used in revising the burden of proof when a patient applies to an MHRT for release. Prior to the HRA, the burden was effectively with the patient rather than the hospital authorities. In the case of *R v MHRT, North and East London, exp, H*,¹²⁷ the Court of Appeal decided that

¹²⁴ *Ibid.*, Foreword by the Secretary of State for Health.

¹²⁵ *R (Wilkinson) v RMO Broadmoor Hospital* [2001] EWCA Civ 1545.

¹²⁶ ECHR Article 3, Prohibition of torture or inhuman or degrading treatment or punishment; Article 8, Right to respect for private and family life, home and correspondence.

¹²⁷ *R v MHRT, North and East London, exp, H*, (2001), EWCA Civ 415.

such a presumption breached the Convention, and the 1983 Act was in need of amendment.¹²⁸

Though for the moment, the majority of challenges under the HRA tend to revolve around questions of procedure, for example, unwarranted delay, *R v MHRT South and West Region, ex p. C*,¹²⁹ and *R v MHRT ex p. KB and seven others*¹³⁰ on the basis of breaches under Article 5.(1) & 5.(4).

Importantly, the HRA via article 5.(4) created significant procedural safeguards in relation to detention:

“Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.”

The HRA itself does not act to change the law *per se*; instead, it served (and continues to do so) to illustrate procedural and practical failings that may fail to comply with the UK’s obligations under the ECHR. As such, it was inevitable that there may be occasions where the outcome is less than satisfactory.

One area where this has proved to be problematic is the ‘right to care and treatment’. In *Johnson v UK* (1997),¹³¹ the European Court held that a discharge could be ordered subject to conditions that allow the patient’s progress after discharge to be overseen, and that the time required in implementing those conditions could justify delaying the release so long as the delay was not unreasonable.¹³² The court also held that the necessary conditions and safeguards were not implemented and that continued detention could not be justified under art 5(1) (e). The case of *Johnson*, underlines some of the practical difficulties that hospitals and social services departments

¹²⁸ Remedial Order. (2001) Mental Health Act 1983, Order 2001. *SI 2001/37/12* London, The Stationery Office.

¹²⁹ *R v MHRT South and West Region, ex p. C* [2001] MHLR 110.

¹³⁰ *R v MHRT ex p. KB and seven others*, (2002) EWHC Admin 639.

¹³¹ *Johnson v UK* (1997) 27 EHRR 296.

¹³² To comply with article 5.(1).

encounter when faced with limited resources in discharging their obligations to patients.

Following a number of domestic cases,¹³³ the law remained unsatisfactory, Genevra Richardson commented that:

“...the patient might be required to remain in hospital simply because of the failure on the part of the relevant authorities to provide the resources necessary to implement the order in the community...In such circumstances would the patients prolonged detention become unlawful under article 5(1)?...And if so, should the tribunal have the powers to order the necessary resources to be provided?”¹³⁴

In view of the amendments to s17a-g by the MHA 2007, the issue of prolonged unwaranted detention is certainly relevant, particularly if the circumstances of the detention fail to meet the *Winterwerp criteria*.

On the face of it, although there would seem to be little progress in achieving a positive SEC rights culture in regard to substantive areas of mental health legislation such as securing the right to treatment for all, freedom from discrimination and social exclusion.¹³⁵ The implementation of the HRA has highlighted a number of shortcomings in mental health legislation, a position that policy makers have been quick to address.¹³⁶ The incorporation of the HRA into domestic law, though not specifically intended to address mental health *per se*, certainly strengthened the case to continue the process of reform begun by New Labour in 1998 with the commissioning of the Richardson Committee’s report.¹³⁷

¹³³ *R (k) v Camden and Islington Health Authority* (2001) EWCA Civ 240 & *W v Doncaster Metropolitan Borough Council*, (2004) EWCA Civ 378.

¹³⁴ Richardson, G. (2005), ‘The European Convention and mental health in England and Wales; moving beyond process’ *International Journal of Law and Psychiatry*, 28, p.136.

¹³⁵ *Op. cit.* pp. 136-137.

¹³⁶ Department of Health. (2000) *White paper reforming the Mental Health Act 1983 Parts 1 and 11 Cm. 5016*, London HMSO. (para. 2.9).

¹³⁷ Department of Health (1999) *Review of the Mental Health Act 1983. Report of the expert committee*, London, DoH.

This was followed in 2002 by the publication of a Draft Mental Health Bill.¹³⁸ The Bill was centered on the notion of ‘*dangerousness*’ with its central premise focused on the reduction of the risk to the general public by those with mental disorders. The criteria for the use of involuntary powers in the Bill were largely a repetition of those contained within the 1983 Act, but ignored the Expert Committee’s recommendation that any reforms must be expressly concerned with preserving autonomy as a central principle for reform. Consequently, commentators¹³⁹ and interest groups¹⁴⁰ feared that the Draft Bill was fundamentally flawed and discriminatory towards those with mental disorders. The Bill as a whole attracted widespread opposition from all stakeholders concerned with the provision or use of mental health services and was subject to a critical report from the parliamentary Joint Committee on Human Rights.¹⁴¹ The government then published a revised Draft Mental Health Bill¹⁴² that was submitted for pre-legislative scrutiny by a committee of both Houses of Parliament.

The report by the Joint Committee on Human Rights made a number of recommendations (107 in the first report).¹⁴³ The report was critical of the Government’s vague reliance on ‘Codes of practice’ and recommended that future legislation should follow the example of the Mental Health (Care and Treatment) (Scotland) Act 2003, by setting out clear ethical principles at the start of the Bill; and that further provisions of the Bill must reflect and support those principles,¹⁴⁴ and that future legislation should include a principle regarding incapacity which should be directly expressed as one of the

¹³⁸ Department of Health, 2002a *Draft Mental Health Bill*. Cm 5538-1, London, The Stationery Office.

¹³⁹ For example see Fennel, P. (2002) ‘Reforming the Mental Health Act 1983: ‘Joined up Compulsion’ *Journal of Mental Health Law*, 5. pp.5-20.

¹⁴⁰ Royal College of Psychiatry, (2002) Response to the Draft Mental Health Bill, *Journal of Mental Health Law*, 8. pp. 376-79.

¹⁴¹ Joint Committee on Human Rights. (2002), *Draft Mental Health Bill*. HL Paper, 181 HC 1294, London, The Stationery Office.

¹⁴² Department of Health (2004a), *Draft Mental Health Bill*. Cm 6305-1, London, The Stationery Office.

¹⁴³ Joint Committee, House of Commons and House of Lords. (2004) *Draft Mental Health Bill*. HL Paper, 79 HC 95, London, The Stationery Office.

¹⁴⁴ Joint Select Committee. (2004), para 66.

conditions for the use of compulsion such as provided by clause 57 (3)(d)¹⁴⁵ of the Scottish Act.¹⁴⁶

The Committee also expressed reservations concerning the possible overlap and lack of provision in the Bill regarding the Mental Capacity Act 2005. That further reform was still needed for human rights compliance was highlighted by the governments response to the EctHR's decision in the '*Bournewood case*,'¹⁴⁷ where the government acknowledged that further procedural safeguards were necessary for those incapacitated patients who were not subject to mental health legislation but who's treatment involved deprivation of liberty. It should be noted that both the Richardson Committee's original analysis and the subsequent Select Committee's pre-legislative scrutiny reports reiterated that respect for principled autonomy should be fundamental to any proposed reforms.

In its response to the Joint Committee's recommendations regarding autonomy, the government rejected both the findings of Professor Richardson and the recommendation of the Joint Committee that future reform should consider the Scottish Act as a starting point, arguing that:

'It is not safe to assume that there is a link between the severity of a condition-and therefore the need for treatment-and the persons ability to make decisions'¹⁴⁸

In effect sidestepping an issue that was seen as crucial by most stakeholders and had gained a degree of statutory protection north of the border.

However, faced with mounting opposition and lack of parliamentary time, the 2004 proposals were effectively abandoned.

¹⁴⁵ s. 57(3), (d) that because of the mental disorder the patient's ability to make decisions about the provision of such medical treatment is significantly impaired, and; (e) that the making of a compulsory treatment order is necessary.

¹⁴⁶ *Ibid.*, para 71.

¹⁴⁷ H.L. v UK 45508/99 (2004) ECHR 471, 'Informal' compliant incapacitated patient was deprived of his liberty, with lack of procedural safeguards or access to court, in breach of Art 5(1) and (4).

¹⁴⁸ Department of Health. (2005)*Government response to the report of the joint committee on the draft mental health bill 2004*. London, DoH, p.16.

In March 2006, the then Health Minister, Rosie Winterton announced:

‘...a fresh approach to radically overhaul mental health law...as she outlined new proposals for a bill to amend the existing Mental Health Act...this new approach will fulfill our commitment to delivering mental health services through a stream-lined bill which will be simpler to understand and less costly to implement than previous proposals.’¹⁴⁹

Subsequently the amended Bill was introduced to Parliament on the 16th of November 2006, following the various committee and report stages with considerable time spent on amendments by the House of Lords in support of points raised by the Mental Health Alliance and others, the bill advanced on the 4th of July 2007,¹⁵⁰ receiving Royal Assent on July 19th 2007, bringing to an end, a reform process first begun by New Labour in 1998.

1.6 Conclusion

That recent reforms to the UK’s mental health legislation have proved to be so arduous a process can be argued as a result of a variety of factors, many of which are historically entrenched. From the initial beginnings in the Chancery Courts where the protection of property was seen as the fundamental aim, to the introduction of the poor law, to a shift in the ‘substance and nature’ of mental disorder; ‘*Hadfield’s and M’Nauhten’s* case’s’ are examples of how policy can be subject to competing forces, both internal and external. Historically, there has always been a conflict of interest between the rights of the individual, the rights of society and the mechanism (policy) by which both of these can be realised.

In the late eighteenth and nineteenth centuries there was a notable move in the way in which the treatment of the mentally ill changed from piecemeal confinement to a more humane and therapeutic perception of care, for example the opening of the Quaker retreat in York. Thus indicating the

¹⁴⁹ Hansard vol 444, Col 29WS 23rd March 2006 & Department of Health press release 23rd of March 2006.

¹⁵⁰ Hansard, Vol 462, cols 1040-1054.

beginnings of a more humanitarian attitude rather than the custodial approach that had for so long been the province of the private madhouses.

The beginning of the period of the 'great confinement,' following the County Asylums Act, though laudable in its endeavor, not only began a long period of institutionalised care, (a positive development at the time), but also of institutionalised policy, arguably, a negative and ultimately restrictive pathway for further reform. Critical analysis suggests that once established, institutions are, for a number of reasons difficult to change,¹⁵¹ for example, the post war closure of the old asylums (on humanitarian grounds) was fundamentally hampered in that the resources required (staff, finance) for change were effectively tied up within the existing asylum system.

More critically the general climate in social thinking changed radically in the latter half of the twentieth century, in policy terms political and civil rights had become part of the agenda. Klug,¹⁵² argues that advances in the progress of human rights has not been achieved incrementally but through three waves or key moments in modern history, the French and American revolutions, the period between the end of World War II and the demise of communism and the Globalisation of the 1990's. As a model, Klug's analysis is certainly applicable to mental health policy. The end of the eighteenth century saw the abandonment of the old madhouse system and a new era in humane treatment. The post war period with the birth of the welfare state and the new rights culture in Europe (the ECHR) brought considerable gains in generating a second wave of PC rights and ESC rights, in terms of mental health reform, and these were reflected in reformed legislation, the 1959 and 1983 acts and a policy shift towards community care.

¹⁵¹ Pierson, P. Argues that institutions themselves become restricted and encumbered within their own structure and framework and therefore find it difficult to change direction. (2001), *The New Politics of the Welfare State*, Oxford: Oxford University Press.

¹⁵² Klug, F. (2001), The Human Rights Act - a "third way" or "third wave" Bill of Rights, *European Human Rights Law Review*, pp 361-372.

Carpenter¹⁵³ argues that the closure of the old mental hospitals by the Conservative Government was the beginning of a pathway change providing an opportunity for a third wave of improved participatory and social rights. Whilst initially, following the NHSCCA, it appeared that some substantial gains were possible as to SEC rights.

However, the killing of Jonathan Zito by Christopher Clunis abruptly changed the dialogue from one of rights to one of risk. Subsequently, further reforms under New Labour remained constrained on the premise of social control on the grounds of public interest and continuing medical paternalism on the basis of 'best interests.'

Arguably, the MHA 2007 as a piece of amended legislation has done little to advocate a third wave of positive rights; it has for the most part been concerned with the HRA and ECHR compatibility of an existing body of law rather than the hoped for paradigm shift in care and treatment. That it is inherently associated with statutory compliance as a central tenet, has effectively consigned the 2007 Act as a restatement of CP rights rather than a positive change in direction towards a third wave of ESC rights. In a final statement from the Mental Health Alliance on the implementation of the 2007 Act, the Alliance stated that:

"...the Government's approach has been profoundly paternalistic and authoritarian. The need for checks on the power of clinicians has been blocked at every turn: 'every restriction on their power is a patient not treated' was a frequently made claim. Efforts to enhance patient choice were similarly resisted. The end result is that the Mental Health Act remains profoundly stigmatising... Overall, the 2007 Mental Health Act will go down in history as a missed opportunity. While other countries, often with less well-developed mental health services, are fundamentally modernising their mental health laws, our already outdated law has at best been mildly improved."¹⁵⁴

¹⁵³ Carpenter, M. (2009) A Third Wave, Not a Third Wave? New Labour, Human Rights and Mental Health in historical Context, *Social Policy and Society*, 8:2 Cambridge University Press. p. 216.

¹⁵⁴ Mental Health Alliance, (July 2007), *The MHA 2007: The Final Report*, London, Mental Health Alliance.

Notwithstanding this, there may as yet be further constructive dialogue towards a positive for duty on public agencies. The argument that having a subjective body of law to regulate mental illness will inevitably foster discrimination and stigmatization remains: There is however, a broader perspective for the future. The implementation of the Equality Act 2006¹⁵⁵ proposing the merger of the Equal Opportunities Commission; the Commission for Racial Equality and significantly the Disability Rights Commission, coupled with the potential for choice promised by the proposed reforms to the NHS Constitution¹⁵⁶ should provide a substantive degree of latitude for future challenges in using the HRA. Further discussion on the new 2007 MHA Act will be the subject of the next Chapter.

¹⁵⁵ Equality Act 2006 Royal assent 12th February.

¹⁵⁶ Lord Darzi's review of the NHS, High Quality Care for All, NHS Next Stage Review Final Report (CM 7432, June 2008, TSO London), concluded there was a case for an NHS Constitution to enshrine the principles and values of the NHS in England.

Chapter 2: The 2007 Mental Health Act

An Act to amend the Mental Health Act 1983, the Domestic Violence, Crime and Victims Act 2004 and the Mental Capacity Act 2005 in relation to mentally disordered persons; to amend section 40 of the Mental Capacity Act 2005; and for connected purposes.

[19th July 2007]

Introduction:

The Mental Health Act 2007 gained royal assent¹⁵⁷ after eight years of hard fought controversy and parliamentary debate. The creation of wider powers to detain people with personality disorders, new professional roles and the introduction of supervised Community Treatment Orders (CTO's) had been central to government policy for reform since the parliamentary process began in 1998 with the Richardson Report.¹⁵⁸ Following on from the previous chapter, this chapter will consider one overriding question; has the 2007 Act improved the 1983 Act for service users, and achieved a better outcome for those who have to live with the consequences? Reviewing the more relevant amendments from three distinct perspectives will approach this question. Firstly, has the new Act provided any positive gains in terms of rights? Secondly, has the new Act failed to address the aspirations of those who are directly affected by the legislation? And finally, is the introduction of Supervised Community Treatment, arguably the most contentious part of the amending legislation, a viable alternative to continued detention for some patients?

2.1 New definitions of mental disorder and medical treatment

A finding of mental disorder in law can have profound consequences for the individual, including the possibility of indeterminate confinement. The importance in exercising such power by the state over the individual must,

¹⁵⁷ <http://www.legislation.gov.uk/ukpga/2007/> (Accessed 21st July 2007).

¹⁵⁸ Department of Health (1999) *Review of the Mental Health Act 1983. Report of the expert committee*, London, DoH.

understandably, be conducted with considerable justification with clearly defensible criteria. Equally, the state in exercising its powers has an obligation to protect the vulnerable. How the use of state power is exercised is singularly dependant on the concept of what amounts in law, to a mental disorder.

One of the central policy aims for the Labour Government in amending the 1983 MHA was to ensure that patients who required treatment would be able to receive treatment and that no one would fail to receive the care they needed because they fell outside the existing statutory definition[s] of what would or would not amount to a psychiatric illness for the purpose of the Act.

The previous definition of mental disorder s.1(2) has been abolished by the amendments of the MHA 2007, it is no longer split into the four distinct classifications of; mental illness, mental impairment, severe mental impairment and psychopathic disorder.

Section 1(2) now states that “mental disorder” means any disorder or disability of the mind, "mentally disordered" shall be construed accordingly.¹⁵⁹

Though the new definition would seem to extend the remit of the Act, with the understandable concerns that the definition could be over-zealously applied by the medical profession to various conditions, for example, Aspergers Syndrome, the Autistic Spectrum Disorder (ASD) and acquired head injuries,¹⁶⁰ etc, thereby increasing the number of people potentially falling within the scope of the MHA,

¹⁵⁹ A single definition now applies throughout the Act – “any disorder or disability of the mind - which should be determined -in accordance with good clinical practice and accepted standards” (Code of Practice 3.2). *Subsection (4)* of section 1 introduces Schedule 1, Part I of which replaces references in the 1983 Act to the four categories of mental disorder with references simply to mental disorder. The effect is to widen the application of the provisions in question to all mental disorders, not just those which fall within one of the four categories (or the particular category or categories to which the provision applies).

¹⁶⁰ 2007 Act explanatory notes paras 17, 19 & Schedule.

The issue of a wider definition was the subject considerable debate at the bill stage; as Professor Richardson explained:

“It is a sort of lobster pot; it is easy to get in, but it is very difficult to get out because the broad conditions are very difficult not to meet”¹⁶¹

Section 1(2A) now defines learning disability as a state of arrested or incomplete development of the mind, which includes significant impairment of intelligence and social functioning. It cannot amount to a mental disorder for the purpose of certain provisions¹⁶² unless it is associated with abnormally aggressive or seriously irresponsible conduct.

The specific definition of learning disabilities within the Act has done much to address the ambiguity of the previous inclusion of mental impairment and severe mental impairment as separate sub-categories of mental disorder. The distinction between the two conditions was previously defined as a *significant* impairment of intelligence and social function in the former and *severe* impairment of intelligence and social function in the latter, and therefore open to considerable latitude in diagnosis and effect,¹⁶³ and as such, the distinction was often difficult to justify.¹⁶⁴ An individual with *significant* impairment would have been subject to conditions relating to long-term civil confinement *only* if a *treatment* was available that was likely to alleviate or prevent a deterioration of his condition,¹⁶⁵ no comparable safe-guard applied to individuals with *severe* impairment regarding confinement.¹⁶⁶

¹⁶¹ Joint Committee on the Draft Mental Health Bill, Session 2004-2005, vol II, 27th October, Q. 11, p. 15.

¹⁶² As per s1 (2B). sections 3, 20, Admission for medical treatment, 7, 37. Guardianship, 17A, 17E & 20A, STO's and renewal of CTO's. 35, 36. 37, 38 & 45A, Criminal remands for reports, treatment, hospital orders, interim hospital orders, hospital and limitation directions. 47, 48, 50, 51, 52 & 53, Transfer directions. 72(1), (B), (C) & 4, Discharge from treatment, detention, SCT and Guardianship.

¹⁶³ Initial assessment of disability is usually based on IQ; a common tool used to measure general intellectual functioning for the adult population is the Wechsler Adult Intelligence Scale. The mean of the scale is 100, and standard deviation is 15. More than two standard deviations below the mean would suggest the presence of learning disability (IQ of 70 or less). <http://www.bild.org.uk/pdfs/05faqs/ld.pdf> Accessed 25th June 2011.

¹⁶⁴ The author has considerable experience as a support worker in the fields of disability and mental illness; many clients (patients) often exhibited periodical episodes of aggression as part of their impairment. From a clinical perspective, the diagnosis would (for the most part) remain the same, however, the degree of aggression or the absence of aggression would *define* their legal status under 1983 Act, either s.1 (2) (B), or s.1. (2) (C).

¹⁶⁵ MHA 1983, s.1, (2) (B).

¹⁶⁶ MHA 1983, s.1. (2) (C)

Arguably, the separate definition relating specifically to learning disabilities will help to address the stigma and difficulties that people with learning disabilities have had in accessing mainstream health care and support services.¹⁶⁷ Although people with learning disabilities make up only a small percentage of the population in the UK, they are disproportionately at risk of developing severe mental illness; rates of psychosis and mood disorders among individuals with learning disabilities are significantly higher than the general population. Research into the epidemiology of mental health problems in people with learning disabilities puts prevalence rates at 20.1% to 22.41%, compared to 16% in the general population.¹⁶⁸

Section 1(2A) should help to identify those with borderline intellectual disabilities and mental disorders¹⁶⁹ who often fall between services because their needs cannot be met by standard mental health provision.¹⁷⁰

The new single definition of Mental Disorder has addressed the previously unsatisfactory definition of “Psychopathic disorder” which stated:

“Psychopathic disorder” means a persistent disorder or disability of the mind (whether or not including significant impairment of intelligence), which results in abnormally aggressive or seriously irresponsible behaviour on the part of the person concerned.”

Firstly, the use of the term *psychopathic disorder* has little substance within the medical profession itself, preferring instead the alternative definitions and diagnostic criteria listed in the International Classification of Diseases (ICD-10) under the generic heading of Disorders of Adult Personality or Behaviour,¹⁷¹ or

¹⁶⁷ Department of Health, (1999a). *Facing the Facts. Services for People with Learning Disabilities. A Policy Impact Study of Social Care and Health Services*. London: The Stationery Office.

¹⁶⁸ Royal College of Nursing, (2010), *Mental health nursing of adults with learning disabilities*. London, RCN. p. 13.

¹⁶⁹ *Ibid.*, Royal College of Nursing, RCN Guidance, pp. 12-13.

¹⁷⁰ CQC, National Mental Health Development Unit. *Count me in: Results of the 2008 national census of inpatients in mental health and learning disability services in England and Wales*. “The Commission’s national audit of learning disability services identified that general health services, care planning, and other aspects of care are poorer for people with learning disabilities in some organizations”, p. 60.

¹⁷¹ ICD-10. F60-F69. pp. 154-174.

more recently in the UK, as Antisocial or Dis-social Personality Disorders,¹⁷² both of which encompass a wide range conditions based upon abnormal behaviour[s]. Secondly, for treatment to be made available, the individual's behaviour[s] needed to exhibit a level of conduct that resulted in abnormally aggressive or seriously irresponsible behaviour.

Historically, there has been considerable academic discussion as to what amounts to abnormal behaviour, (Szasz, Tennent, Gostin etc)¹⁷³ and more recently, *Personality, Personality Disorder and Violence: An Evidence-based Approach* by McMurran and Howard,¹⁷⁴ all of which have considered the difficulties in the diagnosis of conditions where certain characteristics of behaviour and personality could be defined as mental disorders without any obvious mechanisms that would distinguish them from similar normal behaviours.¹⁷⁵ The courts however have adopted a more pragmatic response as to what amounts to a personality disorder as the case of *R v Deighton* illustrates, where LJ Longmore stated that:

"The courts must continue to resist the temptation to medicalise normality"¹⁷⁶

In a similar vein, the Code of Practice in chapter 3, para 6 states the following:

¹⁷² <http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/personalitydisorders/pd.aspx> Accessed 21st Sept 2009.

¹⁷³ Szasz, T. (1970) *Ideology and Insanity: Essays on the Psychiatric Dehumanisation of Man*, Tennent, et al (1993) 'Is Psychopathic Disorder a Treatable Condition?' *Medicine Science and Law*, vol. 33.

¹⁷⁴ McMurran, M & Howard, R. (2009). *Personality, personality disorder and violence*. Chichester, Wiley-Blackwell.

¹⁷⁵ The Author, with several years experience of working in social care, was told by a service user, that after she was sectioned, a psychiatrist told her that keeping a daily diary, something that she had done since childhood, was an indication of an obsessive compulsive disorder (OCD).

¹⁷⁶ [2005] E.W.C.A. Crim. 3131 at para 14. The defendant was convicted of cheating the public revenue by failing to account for the tax due on a disposal of shares, and for income tax and national insurance contributions for a period of eight years. He admitted his failure but denied dishonesty, saying that he had had no intention to defraud. He had 'buried his head in the sand' with regard to overwhelming debts that had accumulated after his call to the Bar. At trial, the defense wanted to call the evidence of two psychiatrists and a psychologist. These experts had not found him to be suffering from mental illness, but two of them had diagnosed a condition called 'Avoidant Personality Disorder'. A third expert had rejected that diagnosis, but said that the defendant had anxious avoidant personality traits. It was argued that this evidence was relevant to the question whether the defendant was suffering from a psychiatric abnormality that could have predisposed him to avoid thinking about what he was doing and its effect, and that this was relevant to the broader questions of dishonesty and intent to defraud.

‘Difference should not be confused with disorder. No one may be considered to be mentally disordered solely because of their political, religious or cultural beliefs, values or opinions, unless there are proper clinical grounds to believe that they are the symptoms or manifestations of a disability or disorder of the mind. The same is true of a person[s] involvement, or likely involvement, in illegal, anti-social or “immoral” behaviour. Beliefs, behaviours or actions which do not result from a disorder or disability of the mind are not a basis for compulsory measures under the Act, even if they appear unusual or cause other people alarm, distress or danger.’

In doing so, the CoP suggests a substantial degree of caution in diagnosis for the medical profession, highlighting the distinction between medical practice and the pragmatic approach of the law.

Section 1(3) previously stated:

“Nothing in subsection (2) shall be construed as implying that a person may be dealt with under this Act as suffering from mental disorder, or from any form of mental disorder described in this section, by reason only of promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs.”

Within the new Act, the former exclusions relating to promiscuity, other immoral conduct and sexual deviancy *alone* have been abolished,¹⁷⁷ implying that previously excluded exceptions would now fall within the remit of the new definition. It is important to note that from a clinical perspective; promiscuity or other perceived *immoral conduct[s]* *per se* would not necessarily amount to a mental disorder, although some *behaviour[s]* such as Fetishism. Sado-Masochism, Pedophilia etc can be categorised as mental disorders subject to certain diagnostic criteria.¹⁷⁸

One result of this, alongside the replacement of the old “treatability” and “care” tests with “appropriate treatment test”,¹⁷⁹ is to make it easier to justify the

¹⁷⁷ Amendments to the exclusions s1. (3.1)

¹⁷⁸ *The ICD-10 Classification of Mental and Behavioral Disorders*, Chapter 5, Classification Codes: F650-F658, pp. 170-172.

¹⁷⁹ The Code of Practice 6.7: The purpose of the appropriate medical treatment test is to ensure that no-one is detained (or remains detained) for treatment, or is an SCT patient, *unless they are actually to be offered* medical treatment for their mental disorder.

6.8 This medical treatment must be appropriate, taking into account the nature and degree of the person[s] mental disorder and all their particular circumstances, including cultural, ethnic and religious

treatment and possible detention of individuals so diagnosed with *deviant behaviour[s]*, whereas before, they may have been previously excluded in the absence of prohibited conduct. This meant that many patients were excluded from being provided with treatment, particularly those with personality disorders for whom there did not appear to be any likely treatment. The new test aims to address this problem by broadening the scope of applicability. The application is further broadened by section 145(1) where treatment is defined as including nursing, psychological intervention and specialist mental health habilitation, rehabilitation and care. This suggests that it is now sufficient for medical treatment to only treat symptoms, which could be perceived as risk behaviour rather than treating the illness itself.

On a positive note, the ‘appropriate’ part of the test¹⁸⁰ requires the treatment to be considered in context by also considering the nature and degree of the mental disorder and all other *circumstances*; this should ensure a patient focused approach in treating disorders. The Code of Practice at paragraph 35.11 states that:

‘...people with personality disorders may take time to engage and develop motivation but they can have other treatment such as nursing and specialist care to manage their risks which can be consider appropriate medical treatment.’¹⁸¹

From a civil liberties (and service users) framework, there are nevertheless obvious concerns that an individual with, for example, a inclination towards promiscuity or other proscribed conduct[s] (formerly excluded in s1 (3) of the old Act, may now presumably fall within the broader definition of s1 (2). The Code of Practice at paragraph 6.6 states that:

‘even if particular mental disorders are likely to persist or get worse despite treatment there may well be a range of interventions which would represent appropriate medical treatment. Never assume that disorders are untreatable.’¹⁸²

considerations. By definition, it must be treatment, which is for the purpose of alleviating or preventing a worsening of the patient[s] mental disorder or its symptoms or manifestations.

¹⁸⁰ MHA 2007, section 3(4).

¹⁸¹ The Code of Practice at paragraph 35.11, p. 324.

¹⁸² Ibid., p. 55.

This suggests that some patients will be seen to be suitable for inpatient treatment even though no effect is likely to be achieved; raising the possibility that under the new test, treatment may be a way of containing someone to control their risk behaviour.

However, definition[s] of mental disorder are not and have never been the exclusive prerogative of the medical profession.¹⁸³ Judicial interpretation of the nature of a *mental disorder* has, as a matter of necessity, gone beyond the limitations of clinical diagnosis in taking both an objective and subjective approaches to statute[s].¹⁸⁴

Courts have always held that the words of statute are not specialist terms and have as a matter of course adopted a common sense approach to interpretation, in the context of the above, some of the commentary from *R v MHRT, ex pt, Clatworthy* illustrates the point under discussion:

“...it may also be observed that it can be contended that sexual deviancy does not mean tendency to deviation but means indulgence in deviation.”¹⁸⁵

The exclusion for substance abuse has been retained. Section 1(3.2) now states that: Dependence on alcohol or drugs *alone* is not considered to be a disorder or disability of the mind for the purposes of s.1 (2) Such exclusions ensure that practitioners carefully consider the basis for treatment with particular regard to the provisions of the Code of Practice 3.10-3.12,¹⁸⁶

¹⁸³ The sole use of a medical model in defining mental disorder[s] is inherently restrictive for a number of reasons. The obvious question is *which* medical approach? There are two prevailing systems of classification[s] used as diagnostic tools, the Diagnostic and Statistical Manual of Disorders (*DSM-IV-TR*), is used primarily in North America, whilst the rest of the world, for the most part, relies on the World Health Organisation’s benchmark, the International Classification of Diseases and Related Health Problems (*ICD-10*). While similar in being the primary starting point in the diagnosis of mental disorder[s], *DSM-IV* and *ICD-10* are by no means identical with considerable differences in the use of various criteria as diagnostic standards. Critics have argued that their respective contents are overly reflective of cultural and political issues within the formulating organisations, illustrating the complexity of interests when adopting a medical approach to defining mental disorder[s]. Kendall, R. (1991) ‘Relationship Between the *DSM-IV* and the *ICD-10*’ *Journal of Abnormal Psychology*, Vol, 100, pp. 297-298.

¹⁸⁴ *M’Naghtens Case*, 1843 10 C & F 200.

¹⁸⁵ *R v MHRT, ex pt, Clatworthy* [1985] 3 All ER 699, pp. 701-2.

¹⁸⁶ CoP s.3.10. Alcohol or drug dependence may be accompanied by, or associated with, a mental disorder, which does fall within the Act’s definition. If the relevant criteria are met, it is therefore possible (for example) to detain people who are suffering from mental disorder, even though they are also dependent on alcohol or drugs. This is true even if the mental disorder in question results from the person’s alcohol or drug dependence.

Although the problem of dual-diagnosis will still need to be addressed on a case-by-case basis, it does not necessarily follow that such people are automatically excluded from the amended Act on the basis of substance misuse alone. If there is an underlying mental health diagnosis, the person is covered by the Act, which may give good reason for the appropriate intervention under the 1983 Act (including a disorder which may arise out of their dependence or use of substance abuse or which is related to it). Treatment for dependence may be given under the Act if it forms part of treatment for a condition, which is a mental disorder as per the new definition in s1. Thus giving a much broader degree of latitude as to what constitutes the appropriate medical treatment.

The effect is that any medical treatment that is available to the patient is appropriate taking account of the nature¹⁸⁷ and degree¹⁸⁸ of the patient's mental disorder and all other circumstances of the case. Further qualification as to the range of what may constitute a mental disorder can be found in the Code of Practice at Chapter 35, People with Personality Disorders; 35. 1-14. It should be noted within the broader definition of mental disorder, the definition, depending on circumstances could include disorders such as Alzheimer's disease and other dementias,¹⁸⁹ Significantly, the changes to s.145 states that: "medical treatment" now includes nursing, psychological intervention and specialist mental health services, rehabilitation and care. Thus giving a much broader degree of latitude as to what constitutes appropriate medical treatment. The effect is that any medical treatment that is available to the patient is appropriate taking account of the nature¹⁹⁰ and degree¹⁹¹ of the patient's mental disorder and all other circumstances of the case.

¹⁸⁷ Nature refers to the particular mental disorder from which the patient is suffering,

¹⁸⁸ Degree refers to the current manifestation of the patient's disorder, *R v Mental Health Review Tribunal for the South Thames Region ex p. Smith* [1999] C.O.D. 148.

¹⁸⁹ New Schedule A1 to the MCA (inserted by Schedule 7) sets out the detailed procedures and requirements relating to standard and urgent authorisations of deprivation of liberty in hospitals or care homes.

¹⁹⁰ Nature refers to the particular mental disorder from which the patient is suffering.

¹⁹¹ Degree refers to the current manifestation of the patient's disorder (*R v Mental Health Review Tribunal for the South Thames Region ex p. Smith* [1999] C.O.D. 148).

The use of the broader definition of mental disorder, the new “appropriate treatment test” and the new definition of what amounts to and can be interpreted as “medical treatment” now makes it possible to include personality disorders as treatable under the Act where previously they were often excluded as being untreatable, for example the Michael Stone case.¹⁹²

2.2 Advocacy, a positive step in the right direction?

The argument for an independent statutory advocacy provision has been longstanding from NGO's and survivors groups despite considerable resistance on the part of Government and the medical profession. Consequently, prior to the implementation of new Act, the majority of advocacy services were voluntary based citizens rights groups such as Mind, Rethink, UK Advocacy Network (UKAN) and the Citizens Advice Bureau etc. Nonetheless, faced with growing pressure for reform directly from service user groups and indirectly, through the Mental Health Commissioners via their biennial reports, the Government commissioned an independent enquiry into advocacy in England and Wales.¹⁹³

The report identified a number of key areas; that if new mental health legislation gives all service users, subject to the powers, of the legislation a right to access a specialist advocacy service, these advocacy services should:

- Become universally available throughout England and Wales
- Be provided to agreed standards
- Use an agreed code of practice.¹⁹⁴

The report also suggested a single definition for specialist advocacy as follows:

¹⁹² Stone had contact with psychiatric services on various occasions, though for the most part was considered untreatable.

¹⁹³ Barnes, d. Brandon, t. & Webb, T, (2002), *Independent Specialist Advocacy in England and Wales: Recommendations for Good Practice*. A study commissioned by the Department of Health. University of Durham, Centre for Applied Social Sciences.

¹⁹⁴ *Ibid.*, p.1.

“Specialist advocacy is independent professional advocacy for individuals who are subject to the powers of mental health legislation in England and Wales.”¹⁹⁵

Following the Durham report, subsequent research by other organisations indicated that existing advocacy provisions at the time were somewhat of a postcode lottery in the services that available. The Citizens Advice Bureau, with nearly 400 offices reported that only 1 in 5 of their branches offered specialist mental health services.¹⁹⁶ Similarly, reports by Get Heard (2007)¹⁹⁷ and Age Concern Cymru (2007)¹⁹⁸ highlighted that many of the points raised by the Durham Report were a matter of continuing concern.

Although both Get Heard’s and Age Concern Cymru’s reports were fundamentally aimed at the ageing populations, Age Concern Cymru’s questionnaire¹⁹⁹ was not restricted to elderly service user groups alone; responses came from forty-five groups across Wales including Rethink, Mind, carers groups and learning difficulties’ organisations.

- Only 23 organisations stated that they provided Advocacy Services
- The lack of a nationally recognised definition of advocacy was apparent in the responses received, with only 6 organisations clearly quoting a formal definition.
- 7 of the 45 services will either have to end or carry on with reduced funding during the next 12 months.

¹⁹⁵ *Ibid.*, p.1.

¹⁹⁶ Cullen, L. (2004) *Out of the Picture: CAB Evidence on Mental Health and Social Exclusion*, at 7.2 p.77.http://www.citizensadvice.org.uk/index/campaigns/policy_campaign_publications/evidence_report_s/er_healthcomcare/out-of-the-picture. Accessed 02.12.04.

¹⁹⁷ Get Heard, *Commissioning Advocacy for Older People: A Common Lack of Approach*, (2007). Southport, Get Heard.

¹⁹⁸ *Advocacy Counts: A Report on Advocacy Provision in Wales*, (2007), Welsh Council for the Elderly, Cardiff. As stated in their methodology: “After some discussion it was agreed that because some organisations provide advocacy informally as part of a wider service, the survey should be sent out to as many advocacy and support services as we could find that work with older people. We also recognised that some organisations work with older people even though that is not their primary client group and this is why we also made contact with them and asked them to complete the survey. Examples of these organisations include mental health organisations and carer’s organisations.” p. 6.

¹⁹⁹ *ibid.*, Appendix 1, p. 37.

With the report concluding that:

“The National Service Framework for Wales recommends the provision of independent advocacy and that commissioners ensure availability. However, our survey instead shows a diminishing service provision rather than the much needed increase in availability.”²⁰⁰

Although the above suggests that prior to the implementation of the 2007 amendments, the provisions in place for dedicated advocacy were not universally accessible; arguably, from a service users perspective, the new Act has done much to address this.

Section 130A - D MHA (functions) defines the statutory requirements for providing Advocacy services in England and Wales in conjunction with the regulations introduced by SI 2008 No. 3166 (The Regulations) ²⁰¹ and the qualifications and guidance contained in the CoP Chapter 20. The MHA 1983 Independent Mental Health Advocates Regulations 2008 state in its guidance for commissioners that:

“The introduction of IMHAs is widely regarded as a positive move, which will help eliminate unlawful or unjustifiable discrimination through supporting patients to become more involved in the decisions made about their care and treatment and to ensure that patients’ rights under the Act are respected. An estimated 42,000 qualifying patients under the Act will be able to benefit from help from an IMHA each year.”²⁰²

Essentially, laying down the spirit of the law, if not the letter of the law in recognising the importance of an independent and accessible advocacy service, has addressed what many have seen as a long-standing omission in human rights, something that service users and other interested parties have welcomed.²⁰³

²⁰⁰ *Op.cit.* p.4.

²⁰¹ Inserted by section 30(2) of the 2007 Act and the Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008.

²⁰² Statement on Equalities Impact Assessment. the Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008.

²⁰³ Mental Health Alliance, Final Report 2007.

Section 130A defines who is responsible for the commissioning (funding) of services, though stated as the “Appropriate National Authority,” this would mean the relevant “commissioning body.” In practice, both the Secretary of State and the Welsh Ministers can arrange for other people to commission IMHA services on their behalf (In England, Primary Care Trusts, in Wales, Local Health Boards).

Section 130A also stipulates the conditions whereby an individual may act as an IMHA within the specified regulations, and the appointment of such individuals.

Though the 2007 Act stops short of defining the role of the IMHA *per se*, s20.2 & 20.3 of the CoP gives a broad definition of the role and its limitations:

- Independent mental health advocacy services provide an additional safeguard for patients who are subject to the Act. IMHAs are specialist advocates who are trained specifically to work within the framework of the Act to meet the needs of patients.
- Independent mental health advocacy services do not replace any other advocacy and support services that are available to patients, but are intended to operate in conjunction with those services.

The role itself is becoming increasingly professional in that all Advocates are expected to undertake on the job training that would lead to a nationally recognised qualification[s] that have been developed by the Department of Health in partnership with City & Guilds and the Welsh Assembly Government.²⁰⁴

²⁰⁴ The Level 3 Certificate in Independent Advocacy consists of four mandatory units and five specialist units. To achieve a full certificate, advocates will need to complete the four mandatory units plus one of the specialist units. The Level 3 Diploma in IMCA - DOLS consists of four mandatory units plus two specialist units on Independent Mental Capacity Advocacy and Deprivation of Liberty Safeguards. To achieve the full diploma, advocates will need to complete the four mandatory units plus these two specialist units.

At a practical level, Independent Mental Health Advocates (IMHA's) will advise patients as to the provisions of the legislation under which he/she is subject to:

- their rights under the Act;
- the rights which other people (eg nearest relatives) have in relation to them under the Act;
- the particular parts of the Act which apply to them (eg the basis on which they are detained) and which therefore make them eligible for advocacy;
- any conditions or restrictions to which they are subject (eg as a condition of leave of absence from hospital, as a condition of a community treatment order, or as a condition of conditional discharge);
- any medical treatment that they are receiving or might be given;
- the reasons for that treatment (or proposed treatment); and
- the legal authority for providing that treatment, and the safeguards and other requirements of the Act which would apply to that treatment.²⁰⁵

IMHA's would also help a patient in obtaining information about and understanding his/her rights and how to exercise those rights.

In order to provide this help, IMHA's will be able to:

- visit and interview a patient in private
- visit and interview any person who is concerned with his/her medical treatment
- be able to attend meetings between patients and the professionals involved in their care and treatment when asked to do so by patients.
- require the production of and inspect any records relating to the detention or treatment in any hospital or registered establishment or to any after-care services provided under s.117

²⁰⁵ Code of Practice: Chapter 20, 20.8.

- require the production of and inspection of any social services authority records which relate to the patient.²⁰⁶

IMHA's will only be able to look at records where the patient consents and has the capacity to do so. If the patient is unable to consent because they lack capacity, the holder of the records must allow the IMHA access if they think that it is appropriate and that it is relevant to the help the IMHA will provide. IMHA's will have a duty to comply with any reasonable request to visit a patient, received from a nearest relative, responsible clinician or approved mental health professional but the patient can decline support from the advocate.

IMHAs will be able to help all qualifying patients, regardless of mental capacity. IMHAs will normally use instructed advocacy; they will only act on instruction from the patient to represent their views and wishes. However, IMHAs may also use non-instructed advocacy with patients who lack the mental capacity to instruct or have difficulties communicating. When using non-instructed advocacy, the IMHA will represent the patient's wishes (as far as those wishes are known) and ensure that the patient's rights are respected, though in such circumstances, it may be appropriate that the services of an IMCA are engaged.

Patients will qualify for an IMHA if:

- they are liable to compulsory treatment under the powers of the Act, (even if they are currently on leave of absence from hospital);
- they are on supervised community treatment;
- subject to guardianship; or
- supervised community treatment (SCT) patients²⁰⁷

For these purposes, detention does not include being detained:

- on the basis of an emergency application (section 4) until the second medical recommendation is received;

²⁰⁶ MHA s130 (B) & (4), CoP: Chapter 20, General guidance s23-28.

²⁰⁷ Code of Practice: Chapter 20, s20.4

- under the holding powers in section 5; or
- under the holding powers in section 5; or in a place of safety under section 135 or 136²⁰⁸

Other patients (“informal patients”) are eligible if they are:

- informal patients who are discussing the possibility of treatment to which s.57 applies (neurosurgery for mental disorder); or
- under 18 and being considered for electro-convulsive therapy or any other treatment to which section 58A applies

In terms of positive outcome, firstly, the right to independent advice as to the subjective reasons for section, treatment and right of appeal; and more importantly, the independent scrutiny of patients and hospital records undoubtedly adds considerable transparency to record keeping regarding treatment, detention and aftercare.²⁰⁹ As the Commisioners noted in their thirteenth report, ward staff often failed to inform patients of their statutory entitlements under s. 132 of the Act, as they concluded after one patient interview:

“Practice in relation to s.132 could be improved. It was not possible to find evidence that attempts to explain patient X’s rights to him had been made over the last year. A decision had been made then that he would not be able to understand his rights but that this would be regularly reviewed. Additionally, it was not possible to ascertain when X had last had a Tribunal although he had had regular managers’ hearings.

*Suffolk, summer 2007.*²¹⁰

Secondly, the inclusion of the requirement for the production of and inspection of any social services authority records which relate to the patient (including care plans) goes some way to ensuring a continuing positive obligation for treatment and the associated support in the community.

²⁰⁸ Code of Practice: Chapter 20, s20.5

²⁰⁹ Healthcare commission: 2006. *Community Mental Health service users survey*. 45% of service users with a standard care plan and 71% of those with an enhanced care plan said they had been offered a copy, although every service user should have one.

²¹⁰ MHAC *Thirteenth Biennial Report 2007-2009, The Mental Health Act: Coercion and Consent*. London, The Stationery Office, p. 60.

That advocacy is now a matter of statutory law, the commissioning obligations²¹¹ imposed on LA's, PCT's and LHB's should address the availability of advice, that up until now, has mostly been catered for by the voluntary sector (as previously discussed). In practice, the continuing development of advocacy will for the most part remain with the voluntary sector²¹² in partnership with LA's, PCT's and others.²¹³ From a strategic point of view, many of the existing NGO's already have a substantial knowledge base of expertise in the field of voluntary advocacy in addition to the extensive support services that they offer to both individuals and their carers.²¹⁴

Post the 2007 amendments, many advocacy services now see their role as part of a more holistic approach to patient welfare by adopting a multi-disciplined attitude towards patient welfare, a position that is increasingly reflected by their mission statements.²¹⁵ It is now up to PCT's and local authorities to ensure no one who is subject to compulsion under the MHA misses out on essential safeguards through lack of access to advocacy.

2.2 Safeguarding consent to treatment.

The new Act has provided two major advances over the use of electro-convulsive therapy (ECT). Firstly, ECT cannot be given to capacitated patients who decline to consent even on the basis of a Second Opinion Approved Doctor (SOAD), other than in an emergency. Secondly, emergency ECT can only be given if it is immediately necessary to save life or immediately necessary to prevent a serious deterioration in the person's condition, though this second

²¹¹ *Independent Mental Health Advocacy: Guidance for Commissioners*, (2008), London, National Institute for Mental Health in England. Mental Health Act 1983: Mental Health (Independent Mental Health Advocates) (Wales) 2008, No. (W.).

²¹² There are a number of specialist advocacy trainers such as U-KAN and specialist advocacy providers such as Pace, promoting LGBT services.

²¹³ The Department of Health has recently commissioned a research team led by the University of Central Lancashire to undertake a review of the quality of IMHA services in England. The study is being undertaken in partnership with Equalities National Council, eMpowerMe (previously Lancashire Advocacy), Aawaz and Manchester African Caribbean Mental Health Services. The study will be completed in 2011 and published in 2012.

²¹⁴ For example, Rethink: "Our wide range of services includes advocacy, carer support, community support, criminal justice, crisis, employment and training, helpline and advice, housing, nursing and residential care, personalisation, respite, IAPT talking treatments and young people. The support we offer spans from acute and long-term care through to practical support and advice for patients and their families. http://www.rethink.org/how_we_can_help/our_services/index.html. Accessed 28th Dec 2010

²¹⁵ <http://www.cadmhas.co.uk/pages/aboutUsEng.html>. Accessed 28 Dec 2010.

strand of the amending legislation was strongly contested in the Upper House, with Baroness Murphy stating that:

“As for emergency ECT under section 62, only very rarely does it seem necessary to give such treatment. I am rather sceptical about it. Someone would have to be profoundly dehydrated to warrant it, and ECT would be a long shot. One would not be able to wait until Monday or a second-opinion doctor was available. I cannot envisage a scenario where a fully capacitated patient who was able to consent would fall into the need for urgent treatment.”²¹⁶

Section 43 amends s131 (Informal admission of patients) of the 1983 Act so that in the case of patients aged 16 or 17 years who have the capacity to consent to the making of arrangements for their admittance to hospital or registered establishment for treatment for mental disorder on an informal basis, they may consent (or may not consent) to such arrangements and their decision cannot be overridden by a person with parental responsibility for them. Further safeguards are provided for children and young people regarding the use of ECT; parental authority cannot override 16 and 17 year olds' capacitated refusal of treatment and a second opinion doctors (SOAD) opinion is automatically needed prior to treatment with ECT.

There will now be an automatic referral for a Mental Health Review Tribunal (MHRT) annually for young patients who have not requested a hearing. The new Act also places additional obligations on hospital managers²¹⁷ and local social services departments in their dealings with under eighteen year old patients, including the suitability of available ward accommodation and follow up care provided by LA's and wherever possible, a CAMHS specialist will be part of the mental health assessment team.

Consent to ECT generally has been strengthened by the new Act, there is now effectively a prior capacity based threshold for considering such authorisation for ECT even when a SOAD certificate is forthcoming. However, this does not apply in the use of a second opinion in reviewing general

²¹⁶ *Hansard* HL, 15 Jan 2007: Col 474 -475.

²¹⁷ New section 131A to the 1983 Act places hospital managers under a duty to ensure that patients aged under 18 admitted to hospital for mental disorder are accommodated in an environment that is suitable for their age (subject to their needs). In determining whether the environment is suitable, the managers must consult a person whom they consider to be suitable because of their experience in child and adolescent mental health services cases, i.e. a suitably experienced AMHP.

treatment, where the position is somewhat fragile at best. Some detained patients do not receive a second opinion; this is for the reason that the safeguard of a SOAD visit after the first three months of treatment is qualified by the responsible clinicians' decision that the patient does not, or cannot, give consent to the treatments being prescribed. In their last report, the MHA Commissioners highlighted the above concerns, stating that there was the need for:

"...the adoption of thresholds for intervention based upon detained patients' perceived mental capacity or incapacity to give or withhold consent. In effect, there is a danger that the threshold becomes whether or not professionals are prepared to recognise as valid a patient's resistance to treatment. As such, the implantation of the revised Mental Health Act's rules regarding the imposition of ECT may be seen as a testing-ground for future moves towards capacity based thresholds of coercion"²¹⁸

Although it is the sole responsibility of the Responsible Clinician (RC) in charge of the treatment to establish the patient's capacity, and to determine whether or not the patient consents, if capable of doing so, the Code of Practice²¹⁹ advises that all circumstances of the patients care should be considered as part of *any* decision making process relating to treatment, implying that an important issue such as consent should in effect be a multi-disciplinary decision.

As a consequence, the Responsible Clinician in charge of prescribing medication within the initial period, would need to establish what the patient's capacity and consent is, in order to decide whether SOAD certification is needed at the end of the three month period of treatment, or, decide that the clinician himself or herself can certify that the patient gives consent to all their medication. Understandably, as highlighted by the Commissioners report (above) there remains considerable disquiet that some detained patients are inaccurately described as giving consent to their treatment, firstly, because they have been asked to agree to treatment without it being adequately

²¹⁸ MHAC, (2009), *Consent and Coercion, Thirteenth Biennial Report; 2008-2009*. paras 3.54-3.56.

²¹⁹ Code of Practice: Chapter 3.

explained in context to allow for informed consent, and secondly because of the effect of latent coercion within the assessment process.

It should be noted that different sets of rules apply in the operation of CTO's, community patients receiving the type of treatment which falls under section 58 or 58A of the 1983 Act²²⁰ must have that treatment certified by a SOAD in accordance with the provisions of Part 4A. For treatment specified in section 58(1)(b), i.e. medication, a certificate is not required immediately, but must be in place after a certain period. This period is one month from when a patient leaves hospital or three months from when the medication was first given to the patient (whether that medication was given in the community or in hospital), whichever is later. The SOAD must certify in writing that it is appropriate for the treatment to be given.

The difficulty of maintaining the independent protective function of the SOAD in setting limits to treatments, will at least in part, be tempered by the responsible clinicians appreciation of a patients' level of capacity in refusing consent and the clinicians subjective application of the guidance set out in the CoP.²²¹ Nonetheless, the continuing endorsement of the safeguards provided by the '*second opinion*' will undoubtedly allow for the continuing development of this area within the common law on the basis of incompatibility with Art 3 and Art 8, perhaps reflecting on cases such as *Wilkinson*.²²²

2.4 Amendments to the presumption of capacity MCA

The Mental Health Act 2007 amends the MCA to include a section on deprivation of liberty. Except in emergency situations a person should not be

²²⁰ Treatment requiring consent *or* a second opinion. s 58 (b) (1) the administration of medicine to a patient by any means (not being a form of treatment specified under paragraph (a) or section 57) at any time during a period for which he is liable to be detained as a patient to whom this Part of this Act applies if three months or more have elapsed since the first occasion in that period when medicine was administered to him by any means for his mental disorder.

²²¹ Cop: Chapter 6.

²²² *R (Wilkinson) v RMO Broadmoor Hospital* [2000] EWCA Civ 1545, *Wilkinson v UK* 14659/02 ECHR 1171, The complainant's application failed for the most part, although the complaint on the basis of Art 8 was upheld.

deprived of their liberty without the authority of the court. Section 50 MCA²²³ inserts a new schedule into the MCA making it lawful to deprive a person of their liberty in a hospital or care home only if a standard or urgent authorisation under Schedule A1 to the MCA is in force or if it is a consequence of giving effect to an order of the Court of Protection on a personal welfare matter, in accordance with the provisions of the MCA. If there is a question about whether a person may be lawfully deprived of their liberty, before a standard authorisation can be obtained, Part 3 of the new Schedule A1 sets out the qualifying requirements that must be met:

- (a) the age requirement
- (b) the mental health requirement;
- (c) the mental capacity requirement;
- (d) the best interests requirement;
- (e) the eligibility requirement;
- (f) the no refusals requirement.

This has imposed a positive obligation on clinicians in deciding whether a deprivation of liberty is warranted. Consideration must also be given to the patient's circumstances including his or her behaviour, wishes, views, beliefs, feelings and values, including those expressed in the past to the extent that they remain relevant, for example Advanced Directives and decisions made by others such as Lasting Powers of Attorney or a court appointed deputy. This will inevitably call for a judgment on the part of the relevant decision-maker in deciding the best way forward in the event of conflicting wishes regarding treatment. The fact that a person cannot (or does not) express a view (or otherwise communicate an objection) does not itself mean that the person should be assumed to consent.

Additionally the extent of capacity or incapacity is relative to any change in the patient's circumstances. If a patient regains competency, further assessment may be required, particularly if the patient had previously been

²²³ Mental Health Act 2007 (Commencement No. 4, s.50(5) & Schedule 7) Order 2009. Mental Health Act 2007 (Commencement No. 10 and Transitional Provisions) Order 2009.

assessed and a certificate issued by a SOAD. As well as addressing the issue of Art 5 raised in '*Bournewood*' these amendments to the MCA make provision to safeguard people in these circumstances as if they had capacity to consent but are refusing to be admitted to (or stay in) hospital or are not consenting to the proposed treatment. In such cases, they would either have to be detained under the 1983 Act, or another way of giving treatment would have to be found.

This highlights the possible difficulties in deciding which statutory route to take, for example, if a person had indicated a refusal to be medicated on the basis of an advanced directive, if treated under the MCA, this refusal, if valid and applicable in the circumstances would be binding. However, detaining the person under the MHA could avoid the advance decision by applying the provisions contained in Part IV (s 63 MHA 1983)²²⁴ medication could then be given despite the advance decision to refuse this form of treatment.

2.5 Changes to the nearest relative

The role of nearest relative (NR) has been contentious for many years mostly due to the inconsistencies between the opinions of the psychiatric professional and other health professionals and the opinions of a layperson appointed as the NR. It should be noted that the origins of the power of the NR to discharge has its roots in the common law of 18th century. The nearest relative would have been the person responsible for the payment of the custodial costs due to the madhouse proprietor; consequently, discharge was more often than not a matter of economic necessity rather than therapeutic intervention.²²⁵

Today, the position is somewhat different; traditionally, psychiatrists have expressed the fear that discharge by the nearest relative leads to a premature release from hospital, which can have a detrimental effect on the patient and

²²⁴ The consent of a patient shall not be required for any medical treatment given to him for the mental disorder from which he is suffering not being a form of treatment to which section 57, 58 or 58A above applies, if the treatment is given by or under the direction of the approved clinician in charge of treatment

²²⁵ Parry- Jones. W, L, (1972) *The Trade in Lunacy*, Chapter 2.

potentially disastrous consequences for the public.²²⁶ However, research has failed to demonstrate any significant difference in the clinical outcome of patients discharged by their nearest relative and those discharged by psychiatrists.²²⁷

Nevertheless, there has been considerable discussion as to the need if any, to retain a layperson in what effectively is an administrative role. In comparative terms, the role of the nearest relative is similar in many ways to that of the AMHP (formerly ASW), as both can apply to the hospital managers for the person to be detained under section 2 or 3, or in an emergency, request assessment, and share information etc.

Previously a patient had no say in who was his or her's nearest relative. In some circumstances, this potentially breached Article 8.²²⁸ The amendments under s26 (6) now includes civil partners in the list of nominated relatives and importantly, the patient can now apply under s29 (3) to displace his nearest relative on the existing four grounds,²²⁹ plus the new ground s29 (3) (e) that the nearest relative is unsuitable, as was the case in *JT v United Kingdom* [2000].²³⁰ The new ground is also available to AMHPs, and others such as carers to apply to the courts for displacement if they feel that the NR is unsuitable.

Although some of the duties of the NR are already within the broader remit of the IMHA and the AMHP, particularly as AMHPs are now charged with acting

²²⁶ Shaw, P. Hotopf, M & Davies, A (2003) "In relative danger?: The outcome of patients discharged by their nearest relative from sections 2 and 3 of the Mental Health Act" *Psychiatric Bulletin* 2003 27: p.52.

²²⁷ *Ibid.*, p.54.

²²⁸ *Lewis v Gibson and MH (by her litigation friend the Official Solicitor)* [2005] EWCA Civ 587. the case arose in connection with a nearest relative (L) whose displacement was sought because she had objected to her daughter (MH) being received into guardianship of a local authority (the Telford and Wrekin Borough Council). L's advisor's argued that the local authority should instead, have applied to the High Court for a 'best interests' declaration regulating MH's care.

²²⁹ MHA, s. 29. (3) (a)(b)(c) & (d).

²³⁰ *JT v United Kingdom* [2000] 1 FLR 909 EctHR. The case involved a patient whose stepfather was said to have sexually abused her. Ms T did not wish her NR (her mother who still lived with the stepfather) to be involved in decisions about her care. The case was settled on the basis that the UK Government would amend the MHA to allow the patient to appoint a NR. Though this was originally part of the 2002 draft bill it has materialised in a more limited format in the 2007 Act, i.e. s29. Section 66 (applications to MHRT) is also amended accordingly.

independently of LSSAs, to remove the NR conceptually as the starting point for providing a statutory safeguard for both patients' and patients' families could arguably amount to excessive interference by the state and provide substantive grounds for an application under Art 8.

However, it is necessary to consider the position of the nearest relative in context; there would seem to be a presumption that the person selected (almost by default) from what amounts to a hierarchy of kin,²³¹ will be the best nominee for the role. In view of the additional safeguards provided by the IMHA, is the role of the nearest relative as an additional safeguard effectively now redundant?

On a positive note, in addition to the role of safeguarding the patient's interests, the nearest relative (and possibly other family members) can have a positive impact on the treatment plan, particularly where aftercare is concerned. Conversely, whether the safeguard principle is likely to be fully realised, depends entirely on the relationship between the nearest relative and patient. If the relationship is good and the nearest relative has the patient's best interests at heart, then the role of nearest relative is an effective safeguard as intended. However, if the relationship is poor, or the nearest relative has little understanding concerning the rights and responsibilities of the role, then the exercise may become counter-productive. Furthermore, if given a free choice, what is the likelihood that the patient will opt for the person most likely to carry out the patient's wishes, even when those wishes may be contrary to medical advice and the patients best interests?²³² However, there remains some feeling that the failure to allow the patient a freer choice in nominating the nearest relative is a missed opportunity.²³³

²³¹ MHA s. 26 (1).

²³² Rapaport, J. (2000), On principle: the Nearest Relative and reform of the Mental Health Act 1983. www.spn.org.uk/fileadmin/spn/user/*.pdf/rapaport_article.doc. Accessed 12th May 2011.

²³³ Mental Health Alliance Final Report July 2007, p. 2. The report lists the "a free choice in choosing the nearest relative" as a hoped for but unsuccessful among the various amendments that were raised in Parliament, many of which were supported in the House of Lords, but which were either not voted on or were deleted in the Commons.

2.6 Principles and the Code of Practice

Section 118 of the Act, as amended, states that the Code of Practice must include a statement of principles that the Secretary of State thinks should inform decisions under the Act. The following matters must be addressed:

- (a) respect for patients' past and present wishes and feelings,
- (b) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006),
- (c) minimising restrictions on liberty,
- (d) involvement of patients in planning, developing and delivering care and treatment appropriate to them,
- (e) avoidance of unlawful discrimination,
- (f) effectiveness of treatment,
- (g) views of carers and other interested parties,
- (h) patient well-being and safety, and
- (i) public safety.

The Secretary of State shall also have regard to the desirability of ensuring:

- (a) the efficient use of resources, and
- (b) the equitable distribution of services.²³⁴

The Code of Practice for England, in chapter 1, sets out the following "guiding principles":

- Purpose principle
- Least restriction principle
- Respect principle
- Participation principle

²³⁴ New subsection (2B) contains a list of issues that the Secretary of State must ensure are addressed in the statement of principles when preparing it. Under new subsection (2C) the Secretary of State must also have regard to the desirability of ensuring the efficient use of resources and the equitable distribution of services.

- Effectiveness, efficiency and equity principle

The Code of Practice for Wales,²³⁵ in chapter 1, sets out similar "guiding principles":

- The empowerment principles
- The equity principles
- The effectiveness and efficiency principles

Faced with intense criticism, the Labour Government agreed to consultation on the inclusion of core principles in the Code of Practice for England and Wales,²³⁶ though critics argued they would have a greater impact if they were included in the new Act itself.²³⁷ In evidence before the Joint Committee, Dr Rowena Daws argued that:

"We think it is absolutely imperative that the principles do get on the face of the Bill. We think it sets very clearly from the outset for legislation that restricts people's liberty and has a strong human rights dimension to it that that legislation should have a clear statement of the principles that underlie it right from the beginning. That is a matter of principle but it is also a much wider issue than that, I think. It will also have an educative value. It is important to provide consistency or help provide consistency for practitioners. I think it will help give service users much more confidence in the law, and we believe that the principles that should be on the face of the Bill are precisely that as fundamental principles. Also, I think if they are left to the Code of Practice there is a problem in that we do not know what the status of the Code of Practice will be, and, of course, it is part of our argument that the Code of Practice should have a statutory force, but, if that is not the situation at the moment and if they are in the Code of Practice, there is only a need to have regard to them and, indeed, they could be changed. We think the principles that we have enunciated really must inform the practice of the legislation."²³⁸

²³⁵ The Mental Health Act 1983 Code of Practice for Wales is guidance to doctors, approved clinicians, managers and staff of hospitals, and approved mental health professionals on how they should proceed when undertaking functions and duties under the Act.

²³⁶ The responsibility for preparing and revising the Code of Practice in relation to Wales was transferred to the National Assembly for Wales, but, by virtue of the Government of Wales Act 2006, this function transferred to and is now exercisable by the Welsh Ministers.

²³⁷ Royal College of Psychiatrists: Briefing on the Mental Health Bill 2006, House of Lords Second Reading: 28 November 2006, s 5.2, p. 11. & Mental Health Alliance, Final Report, 2007: p. 5.

²³⁸ Dr Rowena Daws, Head of Policy and Development, Mind: before the Joint Committee on the Draft Mental Health Bill, Minutes of Evidence, Q 143, 3 November 2004.

In Scotland, in the Mental Health (Care and Treatment) Act (Scotland) 2003 the fundamental principles were written into the legislation. This distinction is important, the inclusion of the fundamental principles in the Act itself suggests that any necessity for clarification is a matter of statutory interpretation to be decided by the courts rather than the medical profession, and as such is legally binding.²³⁹

In England and Wales, the decision to reject the inclusion of fundamental principles in the 2007 Act proper has arguably relegated the notion of principled regulation to the 'second division'. Although the fundamental principles via the proviso of s118 are part of the 2007 Act, their application and interpretation is delegated to the Code of Practice. The main concerns are that the interpretation of the principles is essentially left to the decision maker, normally the Responsible Clinician (RC). In contrast, the Mental Capacity Act has included 'Core Principles' within the Act itself, section 1 states that the following principles apply for the purposes of this Act:

(2) A person must be assumed to have capacity unless it is established that he lacks capacity.

(3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

(4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

(5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.

²³⁹ An extract from the guidance provided by the Scottish Government. "The principles are a set of guidelines for how professionals should work when providing treatment and care under the Act. They do not provide you with legal rights in the same ways as other parts of the Act, but you can use principles as a guide to what you should expect from the people and organisations who provide your care and treatment." <http://www.scotland.gov.uk/Publications/2006/04/24114114/3>. Last accessed 12.10.10.

(6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

In applying the principles, chapter 2 (1) of the MCA Code of Practice states that the statutory principles aim to:

- Protect people who lack capacity and
- Help them take part, as much as possible, in decisions that affect them

Chapter 2 also provides the necessary guidance and explanatory notes for the subjective application of the principles themselves, including practical examples. What is clear in the wording of the accompanying MCA Code of Practice, is that the first three principles support the process before or at the point of determining whether someone lacks capacity; with the last two governing the decision-making process, i.e. 'best interests' and 'proportionality.'

The most obvious distinction between the MHA Code of Practice 'Guiding Principles' and the 'Statutory Principles' enshrined in the MCA is that the former are considerably more objective in their remit in that they includes provisions under the Secretary of States (and Welsh Ministers) direction to 'have regard to the desirability of ensuring the efficient use of resources and the equitable distribution of services,'²⁴⁰ whilst the latter is drafted in terms of positive obligations regarding patient's rights.

Nonetheless, the guidance provided for health professionals in the revised MHA Code of Practice does provide a number of safeguards in applying the principles in practice.

²⁴⁰ s.118, ss 2 (c)

Section 1 states that:

1.7 All decisions must, of course, be lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998.

1.8 The principles inform decisions, they do not determine them. Although all the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context.

1.9 That is not to say that in making a decision any of the principles should be disregarded. It is rather that the principles as a whole need to be balanced in different ways according to the particular circumstances of each individual decision.

Though perhaps the guidance set out in the Code in using the principles lacks the substance of statutory definition, it does however make provision for a flexible approach to their application. Nonetheless, should the RC wish to depart radically from the principles framework, the reasons would have to be recorded and would require a considerable professional justification before doing so.

Although the arguments for having principles as part of the statute as opposed to being qualified guidance contained in the Code of Practice are not new, any analysis must be contextual. Statutory principles infer a greater sense of positive *legal* obligation, whilst the secondary guidance contained within the Code of Practice is inevitably subject to interpretation by the medical profession, and as such, may lack certainty; the real question should be 'how does this work in practice'?

On the one hand, statutes are objective in principle, with their interpretation a matter for the courts, a process that actively engages the law as a safeguard against the possibility of misuse. However should

inadequacies within the statute[s] become apparent, the process of changing a statute is often difficult to justify and time consuming. On the other hand, although Codes of Practice are always going to be a question of professional interpretation, the flexibility they provide at a subjective level is advantageous in a profession where the multi-disciplinary approach to treatment is increasingly the norm. Nevertheless, the amendment of s118 (along with the statutory status of the Code) will effectively make the principles legally enforceable, undoubtedly a step forward in securing service user rights.

2.7 Changes to professional roles

The Act introduces the concepts of the approved clinician, and the responsible clinician. The effect is to broaden the professional base from which decision makers under the Act can be appointed. Mental health professionals with appropriate skills and experience can take over many of the roles given to registered medical practitioners under the 1983 Act. Section 145 of the 1983 Act is amended to provide that an

“ ‘approved clinician’ means a person approved by the Secretary of State (in relation to England) or by Welsh Ministers (in relation to Wales) to act as an approved clinician for the purposes of this Act”.

An approved clinician will in practice be a doctor, although the role is also open to chartered psychologists, mental health or learning disability nurses, registered occupational therapists or registered social workers approved by the Strategic Health Authority or Primary Care Trust (PCT) (or Local Health Board (LHB) in Wales). A recent report carried out by National Institute for Mental Health in England (NIMHE)²⁴¹ (2008-09) identified a total of 13 non-medical professionals preparing for the approved clinician role: nine nurses, one occupational therapist and three psychologists.²⁴²

²⁴¹ Then changed to The National Mental Health Development Unit (NMH DU) in April 2009, then closed on the 31st of March 2011.

²⁴² Hewitt-Moran, T. & Jackson, C (2009) *New Roles Early Implementer Site Project*, A report for the NIMHE National Workforce and National Legislation Programmes p. 5.

Where formerly the decision maker would have been the Responsible Medical Officer (RMO) the Act has been amended to provide for a new definition of the Responsible Clinician.²⁴³

“Responsible clinician” is defined in s34 as:

- (a) in relation to a patient liable to be detained by virtue of an application for admission for assessment or an application for admission for treatment, or a community patient, the approved clinician with overall responsibility for the patient's case;
- (b) in relation to a patient subject to guardianship, the approved clinician authorised by the responsible local social services authority to act (either generally or in any particular case or for any particular purpose) as the responsible clinician

In practise it would seem that the role of RO would for the time being be carried out by a s12 approved medical practitioner,²⁴⁴ however with the role of AC now being open to other suitably qualified professionals, there has been some suggestion that the role of RO may be open to others in the future.

In an article in *The Psychiatrist*, Ian Hall, the Parliamentary Liaison officer for the Royal College of Psychiatrists makes the point that:

“Perhaps the most controversial change is the introduction of the responsible clinician role. Although the new arrangements have the potential to enhance multidisciplinary working, there are concerns they may lead to conflict between professionals and possibly undermine the role of the psychiatrist. Other professions will need to put together portfolios to demonstrate they have the requisite competencies, train to take on the role, and obtain their employer’s support, so the transition is likely to be gradual. We hope it will prove to benefit those subject to the Act’s powers.”²⁴⁵

²⁴³ Mental Health Act 2007 (Commencement No.7 and Transitional Provisions) Order 2008 03.11.08.

²⁴⁴ Zigmund, T, (2008), ‘Mental Health Act 2007, Amendments/Where are we now?’ <http://www.rcpsych.ac.uk/training/aboutthecetc/cetccourses/legal/mentallegislationnews.aspx>.

²⁴⁵ Hall, I. (2009), ‘Changes to the Mental Health and Capacity Acts: implications for patients and professionals’, *The Psychiatrist*, (2009), 33, p. 230.

The NIMHE study also researched staff opinions, finding that for the most part, staff were equally divided with some for the implementation of the new roles whilst others were somewhat more reserved in their opinions, for example:

‘The medics are split. Some are quite enthusiastic and others say it’s never going to happen. Some medics are looking forward to having some of that responsibility placed with people who are better placed to do it. On the other side, people don’t see the value in it and some of that is about losing that control and power. Frontline staff raise their eyebrows at first, and then they think, this could be quite useful for us. The next question is, how do I get to be one. There’s quite a lot of interest, particularly among nurses in working age adult services.’²⁴⁶

The function of health care professionals has been further extended by the changes to the old role of Approved Social Worker (ASW). The new role of "Approved Mental Health Professional" (AMHP) is now defined in s114²⁴⁷ as:

(a) in relation to acting on behalf of a local social services authority whose area is in England, a person approved under subsection (1)²⁴⁸ above by any local social services authority whose area is in England, and

(b) in relation to acting on behalf of a local social services authority whose area is in Wales, a person approved under that subsection by any local social services authority whose area is in Wales.

The obvious distinction with the old role of Approved Social Worker is that the AMHP need not be a social worker. The new role is broadly similar to the role of the Approved Social Worker but is distinguished in no longer being the exclusive preserve of social workers. It can be undertaken by other professionals including community psychiatric nurses, occupational therapists and chartered psychologists. Hewitt-Moran & Jackson’s report for NIMHE

²⁴⁶ *Op. cit.* pp. 11-12.

²⁴⁷ Mental Health Act 2007 (Commencement No.3 and Transitional Provisions) Order 2008 01.10.07.

²⁴⁸ S. 114 Approval by local social services authority.

(1) A local social services authority may approve a person to act as an approved mental health professional for the purposes of this Act.

(2) But a local social services authority may not approve a registered medical practitioner to act as an approved mental health professional.

(3) Before approving a person under subsection (1) above, a local social service authority shall be satisfied that he has appropriate competence in dealing with persons suffering from mental disorder.

indicated that amongst the 2008-2009 cohort, forty-nine non-social worker professionals (all nurses), were either enrolled or due to start training in 2009.

The report noted a number of conflicts of opinion. Staff in some quarters remained doubtful of the ability of nurses, who are very much used to doing as doctors tell them to do, would be able to operate autonomously of their medical colleagues. Others expressed concerns that nurses may lack the values-base and independent decision-making processes that were an essential factor of the AMHP role; with the understandable concern, that in the long term, the broader remit of the AMHP may falter through the medicalisation of the fundamental process.²⁴⁹ However, the NIMHE report indicated that from a funding perspective, Local Authority Social Services departments²⁵⁰ were more willing to release and fund candidates for AMHP training as part of careers progression programs than Strategic Health Authorities; with many Strategic Health Authorities arguing that the lack of funds to pay in-fill staff to cover staff during training remained a problem. Thus, in the interim, it would appear that the majority of AMHP's would be drawn from LASS departments. Nonetheless, the majority of the respondents in the NIMHE report indicated that the amendments implementing the role of the AMHP were a welcome addition in complementing existing services.

2.8 Community treatment orders

The introduction of supervised community treatment has been central to government policy since the reform process began in 1998, regardless of all the evidence provided by the various experts before the Joint Scrutiny Committee that there were considerable doubts as to its efficacy and what criteria should be applied before patients were engaged. In its Report, the committee recommended that:

The evidence we received on the basic principle and efficacy of non-residential orders is finely balanced. We are not wholly convinced by arguments that such treatment is wrong or

²⁴⁹ In practice, most AMHP's are either employed by LASS departments or seconded under s75 arrangements; for example, there are a number of organisations that recruit AMHP's as hourly paid locums, i.e. Medicare Ltd.

²⁵⁰ *Op. cit.* pp. 8-9.

undesirable *per se*, but neither are we satisfied that compulsory treatment in the community is appropriate and satisfactory for anything other than a small minority of patients. In principle, we accept the case for non-residential treatment under compulsion is acceptable, although the evidence is mixed. We recommend that the use of non-residential treatment under compulsion be explicitly limited to a clearly defined and clinically identifiable group of patients.

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The Committee qualified this by stating that:

“...the most common concern aired by witnesses with regard to compulsory treatment in the community relates to the actual provisions in the draft Bill rather than the principle of non-residential treatment. Many witnesses felt that to make non-residential compulsion a "mainstream" part of the Bill *in conjunction with* the currently proposed broad and inclusive conditions for the use of compulsion would lead to significant increases in the numbers of people brought under compulsion, and indeed the numbers retained under compulsory powers.”²⁵²

Suggesting that, although there is a case for community treatment, precautionary measures should be exercised in its use, lest it become an exercise in administration in getting patients from hospitals into the community rather than a subjective approach to treating patients.

Nevertheless, the amended Mental Health Act now provides for Community Treatment Orders (CTO's) through the introduction of new sections 17A to 17G into the MHA 1983. These replace sections 25A to 25J, which were formerly concerned with supervised discharge.²⁵³

²⁵¹ First Report of the Joint Committee of the Draft Mental Health Bill. Session 2004-2005, para 192.

²⁵² *Ibid.*, para 193.

²⁵³ CTO's can be invoked in the case of patients detained under Section 3 of the Act, who are being released from hospital on the basis of continuing treatment in the community. In authorising a CTO, discharge is dependent on particular conditions, such as the regular taking of medication or activities around therapy or rehabilitation. The CTO may also impose residency restrictions similar to those used in Anti Social Behaviour Orders (ASBO's) which would be specified in the Order. If the conditions are breached, patient can be recalled to hospital, for a period of up to 72 hours, during which time a decision can be made as to whether their CTO should be revoked. The responsible Clinician (RC) and AMHP's are involved in assessment and decision making process prior to the initial implementation of a CTO and its possible revocation. The conditions governing SCT's are found in chapter 28 of the Draft revised Mental Health Act 1983 Code of Practice for England ("the draft Code for England") and chapter 28 for Wales.

Three critical questions remain, firstly are CTO's necessary, secondly, do they work and thirdly are they the potential breach of human rights that so many people feared?

The need to maintain contact with discharged patients has unfortunately been illustrated by a number of tragic events. The killing of Jonathan Zito, a musician, at a London underground station on 17 December 1992 by Christopher Clunis, who had been treated for paranoid schizophrenia, prompted considerable public concern as to how a seriously ill mental health patient was free to commit such a serious killing while ostensibly on a conditional discharge from hospital.

Similarly, Ben Silcock, 27, a schizophrenic from London, was mauled by a lion in 1992. He entered the enclosure at London Zoo to feed chickens to the lions and ended up undergoing eight hours of surgery for his wounds. More recently, in 2005, one person was killed and two others injured after Simon Pring, a paranoid schizophrenic, deliberately drove his car onto the pavement in Oxford Street, London. He had suffered mental illness from the age of eleven. At his trial the jury heard on the day of the Oxford Street incident; Pring had 'flipped' because he thought he was under surveillance like a contestant on Big Brother. He had been in the care of a psychiatrist in the months before the incident. Hours before the incident, his father had contacted his son's psychiatric nurse, begging for better supervision.²⁵⁴

There are of course many other equally tragic examples of when supervised community care goes wrong but what is significant is that there are inevitably a number of common factors. One of the characteristics of enduring mental illness is an inability of some patients to understand and reason about their own situation. The move from being in hospital, where effectively all the decisions are made for or on the patients behalf by others, to being discharged into the community is undoubtedly an exercise fraught with difficulty. Should such a discharge take place, there is supposed to be a 'seamless network of care' to help cover the medical, social, housing and

²⁵⁴ The Observer, Sunday 19 November 2006.

other needs of the mentally ill. As history has illustrated, in a small number of cases the system has failed both the individual and the community.

It was often, mistakenly, assumed by the public that supervised treatment in the community (under compulsion) was not available under the 1983 Act; however, supervised treatment was routinely used under a variety of circumstances:²⁵⁵

- Patients subject to guardianship under the Mental Health Act. They may be required to live in a particular place, to attend a health or social care facility for treatment or education or training.
- Section 25 of the Mental Health Act. This is similar to guardianship other than it can only be applied once a person has already been detained in hospital under a treatment order (Section 3 or Section 37) but does include a power to convey patients including the authority to compel a patient to attend a health care or social facility.
- Section 17 leave of absence. Patients detained under Sections 2, 3 or 37 of the Mental Health Act may be sent on leave. Whilst they cannot be forced to have medication in the community there may be grounds for recall to hospital if the patient does not comply with their medication.

Prior to *Halstrom* [1986]²⁵⁶ it was a recognised practice that under certain comparatively rare circumstances, patients coming to the end of their Section would be readmitted overnight in order that their Section might be renewed (under Section 20 of the Mental Health Act), following which they would then again be sent on leave under Section 17. This, effectively, was a form of continuing community treatment order in all but name.

²⁵⁵ Joint Committee on the Draft Mental Health Bill: Evidence Memorandum from The Royal College of Psychiatrists (DMH 24), p. 70.

²⁵⁶ *R v Halstrom*, ex p. W (No 2) [1986] 2 All ER 306.

The conditions in which a renewal of section could take place were further qualified in *R (on the application of DR) v Mersey Care NHS Trust*.²⁵⁷ The Court determined that a patient's Section could be renewed (Section 20) if the patient was required to attend a hospital once a week (this patient was required to attend occupational therapy at the hospital once a week and also to attend a ward round). Similarly, In *R (on the application of CS) v Mental Health Review Tribunal and the Managers of Homerton Hospital*,²⁵⁸ the Court recognised the need to use compulsion in the community to deter patients who no longer required inpatient treatment for their mental disorder from disengaging with treatment. Arguably increasing the opportunity for the renewal of Section 3 patients under what has been termed as the “*long leash*” arrangement.

In CS, the patient was required to attend a ward round (for up to 20 minutes) once every four weeks and saw a psychologist on a weekly basis, the rest of her care being delivered at her home by the NHS Trust's assertive outreach team.

Pitchford J. considered how this approach to CS's treatment worked within the framework of MHA 1983, by stating that:

"Viewed as a whole the course of treatment should be seen, it is submitted, as a continuing responsive programme, during which the need for treatment in hospital and on leave was being constantly reassessed depending upon the circumstances, including CS's responses to assertive outreach and the ward round. Until such time as the transition was complete, the element of treatment at hospital remained a significant part of the whole."²⁵⁹

The court held that the tribunal's decision was not unlawful. The tribunal had been entitled to come to the decision it had on the evidence before it. The RMO's intention had been to break down the cycle of relapse leading to readmission.

²⁵⁷ *R (on the application of DR) v. Mersey Care NHS Trust* [2002] EWHC 1810 (Admin).

²⁵⁸ *R (on the application of CS) v. Mental Health Review Tribunal and Another* [2004] EWHC 2958 (Admin).

²⁵⁹ *Ibid.*, para 44.

Objectively, In view of the number of cases where the use of s17 leave has been unsatisfactory with the practise open to question, and the difficulties in supervising patients in the community, the argument for the necessity of a more robust system of community care has considerable merit, although, exercised within narrow criteria as a restriction against over-utilisation. Undoubtedly, the use of CTO's is likely to grow as a *least restrictive* alternative to hospitalisation; if applied subjectively on a case-by-case basis, CTO's could provide long term benefits for both patients and the community.

At the consultation stage, the government commissioned a report into the effectiveness of compulsory treatment in the community.²⁶⁰ The report found that there was a lack of conclusive evidence about the effects of community treatment orders internationally, though a lack of evidence should not be confused with a lack of efficacy. The review highlighted that there was a gap in the current research and that future studies needed to focus on who benefits from SCT, the effect of compliance with treatment and key outcomes.

Understandably, as the report was commissioned prior to the 2007 Act coming into force there was little domestic data available. There have however been a number of research studies from other jurisdictions where community treatment has been established as part of mental health care. A study in Victoria Australia²⁶¹ concluded that community treatment orders used on discharge from a first admission to hospital were associated with a higher risk of readmission, but CTO's following subsequent admissions were associated with lower readmission risk. The report also concluded that the success of the CTO was linked to the patient's history.

There have been a number of concerns that the government's pre-legislative assessment of the number of patients meeting the criteria for a CTO was primarily based on the numbers of patients under supervision in the

²⁶⁰ Churchill et al (2007) *International experiences of using community treatment orders*, Health Services Research Department Institute of Psychiatry, Kings College London.

²⁶¹ Burgess, P. et al, "Do community treatment orders for mental illness reduce readmission to hospital?" *Social Psychiatry and Psychiatric Epidemiology*, Volume 41, Number 7 / July 2006, pp. 574-579

community at the time.²⁶² Before the Act came into effect, Department of Health Minister of State Lord Warner suggested a gradually increasing percentage of discharged Mental Health Act patients *might* be placed under SCT (year one, 2%; year two, 4%; year three, 6%; year four, 8%; and year five, a 'steady state' of 10%) and the expected number of people with a CTO would rise to the order of 3,000 to 4,000 per year over a five-year period.²⁶³ This would imply that in year one, some 400 to 600 people might be placed under restriction

A report from the Health and Social Care Information Centre stated:

"that as of March 2009, there are at 31 March 2009, 1,755 patients were still on supervised community treatment (SCT), including 22 for whom an independent facility was the responsible provider. Of those subject to SCT, 1,178 were men and 577 were women. The report also shows that during 2008/09, 207 CTOs involved the patient being recalled to hospital and in 143 cases the CTO was 'revoked' and the patient went back to be detained in hospital again. Of the CTOs issued, only 33 had ended with the patient being discharged from the order by 31 March 2009."²⁶⁴

More recently, the Care Quality Commission published its first report monitoring the use of the Mental Health Act in 2009/10, the first figures for which data was available for a whole year since the implementation of the 2007 Act in November 2008.

According to official data collections, there were 4,107 CTO's made in 2009/10, with a total of 6,241 orders in the 17 months from their introduction in November 2008. This is an average of 367 each month: a much greater use of

²⁶² NHS, The Information Centre, *In-patients formally detained in hospitals under the Mental Health Act, 1983 and other Legislation*, Supervised Discharge: Statistics available for the year 2002-03 show 606 patients made subject to supervised discharge in England over that year, and an average of 575 patients made subject to supervised discharge in each of the previous three years (Department of Health (2003) Statistical Bulletin 2003/22). As noted in the Memorandum from the Mental Health Act Commission (DMH 20), foot note, p. 35 The data did not include individuals subject to guardianship and 'restricted' patients,

²⁶³ Cited by Lawton-Smith, S. (2010) Mental Health Alliance, Briefing Paper 2, p. 4. Authors note: International statistics vary between 2 per 100,000 and 50 per 100,000, Lord Warner's comments suggest that of a detained population of approximately 14,500, 10% might be eligible for Non-residential supervision. Hansard col 656-658. 28th November 2006.

²⁶⁴ The Health and Social Care Information Centre, (October 2009), *In-patients formally detained in hospitals under the Mental Health Act, 1983 and patients subjects to Supervised Community Treatment: 1998-99 to 2008-09*, p.10.

CTO's than had been anticipated by the Department of Health before the power was introduced.²⁶⁵

Prompting Jo Williams the Chairwoman to express her concerns that:

"in a sample of over 200 patients, that 30 per cent did not have a history of non-compliance or disengagement. This could be one of the reasons for the number of CTOs, and it poses an important question about the basis on which hospitals are making their judgements when applying these orders... It suggests that 'defensive' practice, increasingly apparent in mental health services driven by concepts of risk rather than just treatment, may lead to CTOs being the default discharge power for detained patients, rather than a measure applied only to those for whom it is really needed."²⁶⁶

Conversely, if considered as the least restrictive alternative to continued detention, then from a service user's point of view, the incentive to continue supervised treatment in a non-residential setting has much to offer. From a practical perspective, every discharge will as a matter of course, include risk assessment as part of the care plan, with the patient having the opportunity to participate and contribute to the agreed care plan. Contextually, the argument is less about treatment under compulsion, but more about therapeutic support, with the onus being on the hospital managers and ancillary services to provide the necessary resources to enable the care plan. As much of the current policy thinking is about patient choice,²⁶⁷ on the basis of the above, it is arguable that future use of supervised treatment, even if only at a minimum level of support, is likely to become the norm rather than the exception.

Do CTO's pose the potential breach of human rights that so many people feared? Though many interested parties²⁶⁸ resisted the introduction of

²⁶⁵ Quality Care Commission, Mental Health Act annual Report 2009/10. The Care Quality Commission's first report on the exercise of its functions in keeping under review the operation of the Mental Health Act 1983 2009/10; According to official data collections, there were 4,107 CTOs made in 2009/10, with a total of 6,241 orders in the 17 months from their introduction in November 2008, of all CTO's implemented up to the end of March 2010 had ended at that time: 922 patients (15%) were returned to detention and 1,043 (17%) discharged from their CTO's. p. 94.

²⁶⁶ Quality Care Commission, Mental Health Act annual Report 2009/10. A summary view on the report, <http://www.cqc.org.uk/mentalhealthactannualreport2009-10/downloadthereport.cfm> Accessed 12 Dec 2010.

²⁶⁷ *New Horizons*, (2009) and *No health, without mental health*, (2011).

²⁶⁸ Lawton-Smith, S. (2005) "A Question of Numbers, *The potential impact of community-based treatment orders in England and Wales*," London, The Kings Fund.

compulsory treatment in the community, the principles provided by virtue of s118 are undoubtedly drafted in reflection of the UK's obligations as set out in the Human Rights Act and as such provide substantive safeguards within the CoP in guiding practitioners in considering using a CTO as a means of compliance.

There are further endorsements and safeguards that have evolved through case law. In the case of *R (on the application of CS) v Mental Health Review Tribunal and the Managers of Homerton Hospital (interested party)*,²⁶⁹ (as previously discussed),

Mr Justice Pitchford stated that:

"...in reality, the application is for a declaration that the claimant's detention was unlawful and damages for her unlawful detention under the Human Rights Act 1998²⁷⁰... The repeated view of the European Court of Human Rights has been that the requirements to be satisfied to protect an individual from arbitrary detention under Article 5(1)(e) are those set out in *Winterwerp v Netherlands* [1979] 2 EHRR 387 at paragraph 39 and *Ashingdane v United Kingdom* [1985] 7 EHRR 528 at paragraph 44...The application of the principle of proportionality to this case leads in any event, in my view, to only one conclusion: the interference with the claimant's freedom of movement and choice were minimal in the context of the object to be achieved, namely her satisfactory return to community care."²⁷¹

This does not however mean that future challenges to compulsory treatment in the community are not on the agenda; in a recent article, "Coercion and Human Rights: A European Perspective"²⁷² Professor Geneva Richardson concluded that:

"The ECHR has set a high threshold of severity before it will regard coerced treatment as unlawful and it places considerable reliance on medical opinion through the notion of medical or therapeutic necessity. It also appears, so far, to attach little weight to the presence of a

²⁶⁹ *Op cit.*

²⁷⁰ *Ibid.*, para 2.

²⁷¹ *Ibid.*, para 49.

²⁷² Richardson, G. "Coercion and human rights: A European perspective" *Journal of Mental Health* 2008, Vol. 17, No. 3.

capable refusal...European human rights law currently fails to capture much of the coercion experienced by patients in practice.”²⁷³

Conclusion

The amendments that have contributed to the creation of the 2007 MHA have provided some substantive gains for service users. The introduction of a broader definition of mental disorder should go some way to help individuals who had previously been excluded to obtain the appropriate treatment they need. A more flexible interpretation of what amounts to medical treatment has effectively extended the availability of post discharge treatment in a community setting including elements of social care.

The new provision for advocacy services to be available as a matter of statutory obligation should ensure that patients’ rights are independently safeguarded from the onset of treatment through to discharge. Additionally, with the majority of IMHA’s currently coming from the voluntary sector, many of the NGO’s involved believe that advocacy per se will fit well with existing resources in supporting service users and their carers.

There have been a number of significant improvements in safeguarding a patient’s consent to treatment, significantly when the treatment proposed is ECT or neurosurgery. The strengthening of the independent role of the SOAD particularly in the case of CTO’s is of considerable importance in monitoring the progress of the CPA. The position of child and adolescent patients has also made considerable gains, particularly regarding hospital accommodation and aftercare and parental consent. The new Act has provided further safeguards regarding consent relative to the patient’s capacity, including the requirement that decision makers must have regard to all of a patient’s circumstances including advance directives.

The inclusion of civil partners as a nearest relative has brought the MHA into line with other areas of the civil law. Though the changes in nominating a nearest relative stopped short of complete choice, the inclusion of s29 in being

²⁷³ *Ibid.*, p. 254

able to apply to the courts to displace an unsuitable nearest relative has addressed the problems discussed in *JT v United Kingdom*. Nevertheless, that the nearest relative has been retained (or able to be removed under s29) in what is arguably a more flexible format is a positive gain for both service users and their families. In the context of the ECHR, the service users right to respect for privacy and family life under Article 8 can be maintained whilst ensuring that he or she does not lose the protections which may come from a family member (in the loose sense) being able to exercise rights under Article 5 on her or his behalf to challenge detention or compulsory treatment.

Though it was hoped that a statement of principle would have been part of the Act proper as is the case in the Scottish legislation, s118 has imposed stringent requirements on medical professionals and all other parties involved in a patient's treatment with regard to the Code of Practice, including substantive aftercare.

Some actors²⁷⁴ see the introduction of supervised treatment in the community, probably the most hotly contested of all the amendments, as a gross encroachment of individual liberty. However, there are undoubtedly a small group of patients that would benefit from close supervision within the community, particularly when the alternative would be continued hospitalisation. The use of principle within the Code of Practice has suggested a robust approach to interpretation in implementing CTO's; arguably the real concern is not the legislation itself but that the availability of the necessary resources at a practical level is sufficient to ensure a smooth transition from hospital into the community. For many patients, the option of non-residential supervised treatment will always be preferable to the acute mental health ward.

There have been some positive gains for service users and their families, however, as the 2007 Act is fundamentally a revision of existing regulation that has its roots in the 1959 Act, the constraints of institutional entrenchment

²⁷⁴ Lawton-Smith, S. (2005) *A Question of Numbers, The potential impact of community-based treatment orders in England and Wales*, The Kings Fund. Mental Health Alliance, Final Report 2007.

and the bureaucracy that are characteristic of such institutions inevitably pose difficult hurdles to overcome, consequently, there are as such, pre-existing limitations. Further discussion towards practical reforms will most likely be reliant on greater participation from NGO's and the voluntary sector.

The next chapter will consider some of the groups of actors that are indirectly affected by mental health issues, and arguably, have exerted considerable influence in shaping policy,

Chapter 3 Reconstructing Mental Health; The Public, the Media and the mentally ill

Christopher Clunis and Michael Stone as case studies.

Introduction

This chapter considers the public's attitude towards mental health and particularly, those who are mentally ill. In broad terms, the discussion begins with a brief overview of the legislation that underpins the system, explores some of the questions that are seen as fundamental flaws within the system and the effect that such misconceptions have on public opinion. More specifically the aim here is to provide a forum for discussion as to how and why - despite the introduction of *Care in the Community* as a working policy - the public in general continue to view mental illness from a negative perspective that fosters discrimination and social exclusion. The Chapter will consider how such attitudes seem to be entrenched in the public's imagination and how this position can be addressed responsibly by some of the actors within this specific area of activity.

The first part of the chapter considers the degree of tension that exists between what may be perceived as the intention of the legislation and the effect the legislation has in practice for service users. The aim here is to illustrate the adverse effects that the implementation of the legislation has on those to whom it is primarily directed and how such effects contribute towards continuing institutional entrenchment and introduce the concept of latent stigmatisation endorsed through policy.

Following this introduction, the second part of the chapter will explore some of the policy considerations used to distinguish the rights of mentally ill individuals from those of others. With reference to various political and social developments in the arena, the cogency of the various rights issues, and the relative allocation of responsibility in approaching potential claims is discussed in some detail. However, within the confines of this chapter, the focus of this

discussion will for the main part consider the issues from a public perspective. In doing so, the discussion will build upon the argument that the continuing institutional position will inevitably lead to the denigration of individual rights in favour of community utilitarianism.

Moving from the arguments outlined in the second part of the chapter, the third section then considers some of the factors that contribute to the dynamics of public opinion. Foremost, this stage of the discourse will begin with an overview of how the public's perception of mental illness has to a certain extent taken on the guise of an urban mythology. This line of argument continues with an analysis of some of the factors that have contributed to such a position; firstly, the characterisation of madness through the medium of film, secondly, the stance taken by the popular press and finally, the relativity and purpose of inquiries into homicides by mentally ill individuals.

It is at this stage of the chapter that the case studies set out at the beginning are considered, providing for a more focused discussion as to how such examples are portrayed in the media. In doing so, the analysis questions as to how far the media is responsible in: 1) Influencing public opinion 2) Coercing government policy 3) Acknowledging wider social issues. More specifically, does the popular perception of mental illness when viewed from a media perspective reflect the reality of a contemporary policy and human rights agenda 4) In acknowledging that there is a wider perspective of social justice in any rights discourse, the final section of this chapter shifts the focus from the public as a community in 'moral panic,' and instead considers the previously outlined relationship of rights and duties to assess the responsibilities of the relevant actors such policy makers and media reporters that are affective in the publics' thinking. It is at this point that the discussion approaches its conclusion, balancing the publics' perceived concerns over safety against the limitation of individual rights

3.1 The Development of Institutional stigmatisation

For many people the Mental Health Act 1983 is an exercise in ambiguity. Arguably, the title of the Act relative to the subject matter is the English Legal System's finest example of statutory misinformation in that Mental Health is seldom granted more than a cursory reference within the body of the Act.²⁷⁵ Referred to in the long title as, "An Act to consolidate the law relating to mentally disordered persons" provides little evidence as to the intention, content, and objectives of the Act.²⁷⁶

Although the Act is the cornerstone upon which the regulation of mental illness rests, the Act is not concerned with mental health in any proactive sense, doing little to promote good mental hygiene. Instead, it is an Act that for the most part addresses the compulsory admission to, and conditional discharge from hospital as its central focus, with somewhat limited provisions safeguarding patients' rights. Successive complimentary legislation such as the Mental Health (Patients in the Community) Act 1995 maintained hospitalisation as a keystone of mental health services and supervised discharge²⁷⁷ as a continuing theme.

The shift in the latter part of the twentieth century from institutional confinement in the old asylums towards care in the community was not without its problems; after rising steadily throughout the first half of the century, the resident population of psychiatric hospital beds reached a peak of 152,000 in 1954.²⁷⁸

²⁷⁵ With exceptions such as "Mental Health Review Tribunal" etc.

²⁷⁶ The 1983 Act is in fact a supplementary piece of legislation consolidating existing statutes' relating to the Mental Health Act 1959.

²⁷⁷ The 1995 statute inserted provisions into the existing legislation providing for care in the community through supervision, ACUS's (After-care Under Supervision).

²⁷⁸ Mind: The history of mental health and community care.

http://www.mind.org.uk/help/research_and_policy/the_history_of_mental_health_and_community_care-key_dates. Accessed 17.02.11.

However, the Initial optimism of the early 1960's following the beginning of the closure of the old asylums was soon replaced with concerns over discharged patients in the community who effectively disappeared from the system.²⁷⁹

Nonetheless, as with any fundamental change in policy, there is an inevitable learning curve to be overcome;²⁸⁰ the development of crisis resolution and community care teams meant that many service users could be treated in their own homes or in the community without the need for hospitalisation. In contrast to the asylum years of the 1950's, the move towards move towards community has substantially reduced the number of patients on hospital wards.²⁸¹

At a practical level, the contemporary argument that patients that can be treated while living in the community are best served by community-based treatment has for the most part been successful in reducing the need for formal admission.²⁸² However, the smaller numbers of individuals who are formally admitted tend to be those experiencing the most acute mental health problems and are either unwilling or unable to engage with local services. That some people are reluctant to engage is often the result of previous experience. In 2000, Mind carried out a national survey of people with experience of hospital services. The results were disturbing. More than half

²⁷⁹ The Psychiatric Rehabilitation Association Research Unit, *'Mental Health of East London in 1966'*, Psychiatric Rehabilitation Association. Kingsland High Street, E.8. The report found that of 174 schizophrenics discharged to known addresses from one mental hospital in Epsom, Surrey, only 94 could be traced within 12 months, of whom only 29 were in satisfactory accommodation, 33 were without employment or occupation, and 28 were neglecting themselves. The fate of the 80 (nearly 50%) who have disappeared is unknown.

²⁸⁰ It should be noted, that although provisions for care in the community had its origins in the 1957 Percy Report, the Survey of English Mental Illness Hospitals March 1994-Monitoring the Closure of the "Water Towers" reported that ninety-two large asylums still remained operational, compare that with 2002 when fewer than twenty of the old asylums remained open. Mahoney, J. (2004), *Outcome Hospital Closure Programme*, National Institute for Mental Health in England. www.fic.nih.gov/dcpp/ppts/mahoney.ppt. Accessed 12.09.08.

²⁸¹ Department of health records show that the number of formal admissions to hospital peaked during the 1990's at 26,900 in 1998-99. Since the 2007 Act, total formal admissions rose to 28,700 in 2008-09 from 28,100 in 2007-08. Total detentions, including detentions subsequent to admission and detentions after removal to a place of safety, rose by 100 to 47,700. *The NHS Information Center for Health and Social care*, (2009) Table 2a, p.25, though it should be noted that many formal admissions would have been for relatively short periods, i.e. 72 hours *as per* s.5(2) & s.5(4).

²⁸² Simmonds, S. *et. al.* (2001), 'Community mental health team management in severe mental illness: a systematic review'. *The British Journal of Psychiatry*, (2001), 178. 497-502. Concluded that Community mental health team management promotes greater acceptance of treatment, and may also reduce hospital admission and avoid deaths by suicide.

(56%) of patients felt that the ward was a non-therapeutic environment, just under half (45%) felt that ward conditions had a negative effect on their mental health, and almost a third (30 %) of patients found the atmosphere on the wards unsafe and frightening.²⁸³ *Ward Watch* in their 2004 report *Environmentally friendly? Patients' views of conditions on psychiatric wards*, voiced similar concerns:

- For some patients, the hospital environment has provided the treatment and support needed to help them recover.
- For others, poor accommodation and security, safety concerns, insufficient staffing levels and intense boredom have exacerbated existing difficulties and created new ones, subjecting patients to an environment that is inhumane where it should be therapeutic.
- Only one in five of patients felt that they were treated with respect and dignity by staff. Almost the same proportion (17 %) stated that they were never treated with respect and dignity by staff.²⁸⁴

In a newspaper interview, Professor Dinesh Bhugra the then president of the Royal College of Psychiatrists admitted that Acute psychiatric wards in England and Wales are now so poor, that he would not use them himself - nor allow a member of his family to do so:

'You don't go to hospital to get hurt, but that's what's happening in our acute psychiatric wards...some are uninhabitable. It's completely and absolutely unacceptable.'²⁸⁵

Understandably, the fear of institutional stigmatisation and the possibility of disempowerment means that for a small number of individuals, mental health

²⁸³ Baker, S, 2000, *Environmentally friendly? Patients' views of conditions on psychiatric wards*, Mind.

²⁸⁴ Mind, *Ward Watch* report (2004) *Minds campaign to improve hospital conditions for mental health patients*, p.19. www.mind.org.uk/Newa+policy+and+campaigns/ Accessed 12th October 2009. Similar concerns were routinely noted by the Mental Health Act Commissioners in their Biennial Reports, see Chapter four.

²⁸⁵ Hill, A. 'The mental health units that shame the NHS', *The Observer*, Sunday June 29 2008.

services are something to be avoided; the prospect of hospitalisation²⁸⁶ is seen as obstructive instead of conducive towards good mental health. Nonetheless, most people who experience mental health problems are satisfactorily treated by their GP's, with many going on to receive either out-patient treatment or admission on an informal basis. There are however, a relatively small number of patients that as a matter of necessity do require formal detention and a greater degree of supervision on discharge.²⁸⁷

In July 1984, an event occurred which had major implications for community mental health care and public attitudes. Sharon Campbell, a former in-patient at Bexley Hospital killed Isabel Schwarz, her former social worker. Campbell had a previous history of attacking others with knives on at least two occasions. Following the publication of the *Report of the Committee of inquiry into the Care and Aftercare of Miss Sharon Campbell*,²⁸⁸ the matter was discussed in the House of Lords where Lord Winstanley²⁸⁹ made the following comments:

"I have no wish to comment in detail on such a lengthy and complex report. I can do no better than quote briefly from an article about the report, not the case, by Dr. Victor Schwarz who is Isabel's father, which appeared in Community Care. The article says: In 3,000 pages of transcripts one pathetic phrase repeatedly obtrudes itself—'with the benefit of hindsight'. Dr. Schwarz goes on to say that it is the business of professionals, doctors and so on, to exercise foresight, not hindsight, that foresight, based on a thorough acquaintance with the established facts and with the detailed history of the patient".²⁹⁰

Although particularly damning of the lack of co-operation between the various agencies, the report did speed up the implementation of the Care Program

²⁸⁶ More discussion is given to the first hand experiences of patients on wards in chapter four.

²⁸⁷ The Care Quality Commission's first report on the exercise of its functions in keeping under review the operation of the Mental Health Act 1983 2009/10; Noted that: according to official data collections, there were 4,107 CTOs made in 2009/10, with a total of 6,241 orders in the 17 months from their introduction in November 2008, of all CTO's implemented up to the end of March 2010 that had ended at that time: 922 patients (15%) were returned to detention and 1,043 (17%) released. p.94.

²⁸⁸ Spokes, J., Pare, M. and Royale, R. (1988). *Report of the Committee of Inquiry into the Care and After-Care of Miss Sharon Campbell*. London: HMSO.

²⁸⁹ Michael Platt Winstanley, 27th August 1918-18th July 1993, had served as Treasury Medical Officer and Admiralty Surgeon and Agent 1953-66.

²⁹⁰ *Hansard*: HL Deb 01 December 1988 vol 502 cc454-72 at 456. It should be noted that Dr Schwarz was at that time an academic member of staff of the Medical School of the University of Manchester.

Approach (CPA) as recommended in the *Griffiths Report*.²⁹¹ Though stopping short of the report's proposal to apportion responsibility to a single agency, which would then commission services from other departments as part of the CPA. Nonetheless, the CPA introduced a system requiring Health Authorities, in collaboration with Social Services Departments, to put in place specified arrangements for the care and treatment of mentally ill people in the community. in formulating aftercare:

- Assessment: Systematic arrangements for assessing the health and social needs of people accepted by the specialist mental health services;
- The formation of a care plan, which addresses the identified health and social cares needs;
- The appointment of a Key Worker (now Care coordinator) to keep in close touch with the patient and monitor care; and
- Regular review, and if need be, agreed changes to the care plan.²⁹²

Although the policy guidelines were explicit in recommending inter-professional working, patient and carer involvement and cooperation between health and social services, the number of catastrophic cases involving the deaths of strangers at the hands of mentally ill patients persisted.²⁹³ The evidence of the Inquiries that followed suggested that the CPA was failing, and that local adherence to guidelines could not be taken as a guarantee of quality service delivery or efficiency. In many respects, community care as a

²⁹¹ Griffiths, Sir, R. (1988) *Community Care; Agenda for Action: A Report to the Secretary of State for Social Services by Sir Roy Griffiths*. London: HMSO.

²⁹² In 1999, the Government undertook a review of the CPA, *Effective Care Coordination in Mental Health Services, Modernising the CPA, A Policy Booklet* (2000) DoH; Integration of the CPA and Care Management — the CPA is care management for people of working age in contact with specialist mental health services. Appointment of a Lead Officer — Each health and social services provider is required to jointly identify a Lead Officer to work across both agencies. Two levels of the CPA were introduced — Standard and Enhanced. Abolition of the Supervision Register — from April 2001, Supervision Registers can be abolished providing the Strategic Health Authority is satisfied that robust CPA arrangements are in place. Reviews of Care Plans — the requirement to review care plans 6 monthly is removed. Review and evaluation should be ongoing. At each review the date of the next meeting must be set. Audit — regular audit will be required to take place looking at qualitative implementation of the CPA. Risk assessment/risk management — risk assessment is an ongoing part of the CPA. Care plans for people on enhanced CPA are required to have a crisis plan and contingency plan. <http://cpaa.co.uk/thecareprogrammeapproach> Accessed 04.02.11.

²⁹³ Christopher Clunis killed Jonathan Zito, Michael Buchanan killed Frederick Graver, both in 1992,

central policy was becoming increasingly overshadowed by a culture of attribution and damage limitation, as opposed to the positive strategic planning originally intended by the implementation of the CPA. In 1994, the Thatcher Government admitted that the provisions for mental health were outmoded in failing both service users and society as a whole. A survey by the Audit Commission found that the favoured policy, of individual, locally based care within the community, was "struggling".²⁹⁴

Subsequent to New Labour's election victory, health-care figured prominently on the political agenda. However, following the Media's robust reporting on a number of high profile offences committed by mentally ill patients,²⁹⁵ the then Minister for Health, Frank Dobson, in the foreword of a Department of Health report, stated:

"Care in the community has failed because, while it improved the treatment of many people who are mentally ill, it left far too many walking the streets, often at risk to themselves and a nuisance to others. A small but significant minority have been a threat to others or themselves. We are going to bring the laws on mental health up-to-date. In particular to ensure that patients who might otherwise be a danger to themselves and others are no longer allowed to refuse to comply with the treatment they need. We will also be changing the law to permit the detention of a small group of people who have not committed a crime but whose untreatable psychiatric disorder makes them dangerous."²⁹⁶

Furthermore, following a number of critical articles in the media condemning government policy over the failure of community care, Dobson commented that:

"We need to look at this right across the spectrum – from people who are just a bloody nuisance to people who may be a danger and against whom legal action needs to be taken."

This is a statement that he later tried to refute as misquoted and out of context.²⁹⁷

²⁹⁴ Audit Commission for Local Authorities and the National Health Service in England and Wales, (1994), *Finding a Place: A Review of Mental Health Services for Adults*, London, HMSO.

²⁹⁵ Michael Stone 1996, killed Lyn and Megan Russel.

²⁹⁶ DoH, (1998a), *Modernising Mental Health Services: Safe, Sound and Supportive*, London: The Stationery Office.

²⁹⁷ Anthony Bevin, "Dobson denies call to scrap care in the community", *The Independent* 19 Jan 1998.

That there has been a departure in confidence from earlier policies advocating social care principles²⁹⁸ had been further eroded by a succession of proposed new bills²⁹⁹ that failed primarily due to civil liberty issues. Nonetheless, the administration indicated that it intended to proceed with the reform process by amending the existing legislation in the form of the Mental Health Act 2007, c12, (Amendments to the Mental Health Act 1983).

For many,³⁰⁰ this is seen as a retrogressive direction in policy that fails to address the reality of a failure that is nearly fifty years old.³⁰¹ To think in terms of reconstructing rather than reforming mental health legislation, it is necessary to examine objectively what are the aims of legislating for mental health. Prior to the 1983 Act, Gostin in his classic critique *A Human Condition* argued, that if mental health needed legislation, it should be refined as a matter of substantive purpose directed toward those that use the service. Within his text, he suggested the following:³⁰²

1. The provision of legal authority for involuntary compulsion for treatment and to enable appropriately qualified persons to direct patients and service users to receive particular forms of services, whether in institutions or in the community, and to provide the appropriate safeguards for service users in relation to the exercise of this authority by professional staff.
2. The establishment of a legal basis for the provision of services, wherever possible offering effective individual and enforceable entitlements.
3. To protect and enhance the civil and social status of persons labelled, diagnosed or treated as mentally ill.

²⁹⁸ Griffiths, Sir, R. (1988) *Community Care; Agenda for Action*, London, HMSO.

²⁹⁹ Draft Mental Health Bill 2002, Cm 5538-I, Draft Mental Health Bill 2004, Cm 6305, HMSO.

³⁰⁰ The Mental Health Alliance's final briefing paper on the 2007 Act, the Alliance consists of over 70 organisations that represent service users, charities and carers.

³⁰¹ The 1983 MHA amended the 1959 MHA.

³⁰² Gostin, L. (1975) *A Human Condition: Volume 1 The Mental Health Act from 1959-1975* London: MIND (National Association for Mental Health).

Though largely ignored at the time as contentious, Gostin's proposals suggested that mental health legislation should be considered as two distinct areas of law: That which embodies civil rights as a matter of principle; and that, which legislates for the pragmatics of implementation and provision (for the main part, the MHA 1983). For the service user, the fear of discrimination and stigma can result in patients being reluctant to engage with services at the outset of their illness, hence for some patients, their enduring experience of mental health services is mainly centred around the formal sectioning process and re-admission. For the public, protection from harm by those seen as mentally ill will always be at the forefront of any debate, with reciprocity of treatment and freedom from discrimination left trailing in its wake.

That such a gulf exists, has in part defined the mentally ill in the public's eyes as '*dangerous others*', In order to gain a more comprehensive understanding of some of the issues that have influenced public opinion and perforce policy decisions, this chapter will now consider the expectation of public understanding, particularly in the context of cinematic depiction and media reporting.

3.2 Public perception, the cinema, the media and the development of an urban mythology

Classic film vignettes from the 1960s and early 70s, such as Jack Nicholson as "Crazy R. P. McMurphy" in *One Flew over the Cuckoo's Nest*³⁰³ or Anthony Perkins as Norman Bates in Hitchcock's *Psycho* undoubtedly have had an impact on the collective psyche in terms of how we perceive mental illness. The continuing characterisation of people with mental disorders has provided a whole genre with a stereotype as a source of material. The filmmaker only has to include a 'homicidal psychopath' as a character and the plot becomes self-explanatory, and any ambiguity in the narrative can be explained by referring to the characters' state of mental health. As an expression of

³⁰³ Kesey, K. (1962), Methuen & Co Ltd London. Later a film directed by Milos Forman, released by United Artists.

identity, films such as *The Shining*³⁰⁴, *Fatal Attraction*³⁰⁵ and *Cape Fear*³⁰⁶ serve only to portray mental illness negatively and in doing so, continue to perpetuate the urban mythology that mental illness inevitably equates to violent derangement, and as such is something to be feared. At the softer end of the medium, children's films such as *Batman* with the villain of the piece inevitably portrayed as a psychotic, though often-comic genius; illustrate mental illness in a way that continues to contribute to an urban mythology that is unsympathetically entrenched in the public conscience.³⁰⁷ The public increasingly perceives such negative portrayals of psychopathy as the norm, with just the occasional exception such as Russell Crowe's biopic account of the life of John Forbes Nash Jr in *A Beautiful Mind*³⁰⁸ and Nicholson's performance in *as Good as it Gets*³⁰⁹ providing a more sympathetic insight into what it means to be mentally disturbed.

The process by which the mentally ill have been characterised in the cinema is open to a number of critical interpretations. For much of the latter half of the twentieth century, mainstream depictions of mental illness, with a few exceptions, shifted between "homicidal mania" (*Cape Fear*, *Psycho* etc) and "comedic dysfunction" (*Me, Myself and Irene*,³¹⁰ *Batman* etc). In context, the stereotypes described are clearly ridiculous, having little resemblance to reality. Nonetheless, such films remain commercially popular in cinemas. Such depictions of mental illness are clearly intended to entertain rather than educate. Conversely, productions such as *A Beautiful Mind* and *As good as it Gets* defy accepted stereotypes, presenting sympathetic portraits of people who are mentally ill, and advance the cinema-going public's understanding of mental illness. Significantly, the underlying sub-text portrays mentally ill people as ordinary people with conflicts and needs common to everyone. This

³⁰⁴ Directed by Stanley Kubrick, Warner Brothers, released 23 May 1980.

³⁰⁵ Directed by Adrian Lyne, released by Paramount Pictures, released September 11, 1987.

³⁰⁶ Directed by Martin Scorsese, starring Robert De Niro, released through Universal Pictures, November 13, 1991.

³⁰⁷ Wahl, O. F. (2003), 'Depictions of mental health in children's media', *Journal of Mental Health*, 12, 3, pp.249-258.

³⁰⁸ *A Beautiful Mind*, (2001) Directed by Ron Howard, Dreamworks SKG, released through Universal Pictures.

³⁰⁹ *As Good as It Gets* (1997), Directed by James, L. Brooks, released by Tristar Pictures.

³¹⁰ *Me, Myself and Irene*, (2000), Directed by the Farrelly brothers, distributed by Twentieth Century Fox.

recent shift in the characterisation of mental illness in film media is important; research has indicated the popular media has a significant part to play in shaping the public's perception of what it means to be mentally ill.³¹¹

The popular press, due to its inherent nature, inevitably runs stories that will try to captivate its readership, the more sensational the better. The use of labelling is a primary feature in news reporting, often incorporating a subtext within the narrative. A violent perpetrator with a mental illness may be described as *a psycho* (a term that has no professional merit) where the adjective intention of diagnosis (psychosis) is displaced as a noun denoting a completely differing perspective, implying to the reader that there is a causal link between mental health and violent behaviour. Had such an offender been suffering from another impairment, such as a broken arm, would he or she have been described as *a broken arm* rather than as *having a broken arm*, highly irregular and of course grammatically absurd? Nonetheless, the exercise of journalistic licence seldom extends to such niceties; rather, when challenged over the use of the word "*Psycho*" in tabloid headlines, one editor pointed out that its very difficult to "*fit long words*" such as "*A person diagnosed with schizophrenia*" onto the front page, in three lines, each with seven characters.³¹² As a consequence, particularly in the tabloids, much of the reporting of mental health issues continues to reinforce the underlying suspicion that mental illness and violence are inseparable.

The media and the press leave the public in no doubt; the mentally ill are seen as violent, unpredictable, and a threat to society. They are often portrayed as unkempt, poor, homeless, and unemployable in a world that is measured by material values. Such images are misleading; the reality is that less than one per cent of the general population will be affected by severe psychosis, whilst in contrast, roughly over half of all women and a quarter of

³¹¹ Hyler.S., Gabbard. G. O. & Schneider,I. (1991) "Homicidal maniacs and narcissistic parasites: Stigmatisation of mentally ill persons in the movies." *Hospital and Community Psychiatry*. 42. 1044-1048. Philo.G. (ed.) (1996) *Media and Mental Distress*. London: Logan.

³¹² Sayce L (1998) 'Stigma, discrimination and social exclusion: What's in a word?' *Journal of Mental Health UK* (7), 331-343.

all men will be affected by a depressive illness before the onset of old age.³¹³ Thus, it is perhaps more realistic to think in terms of 'us' rather than 'them.' Nonetheless, for the mentally disordered, the potential for social exclusion, stigmatisation and discrimination is undoubtedly one of the main stumbling blocks to achieving a semblance of equality. Despite the growing awareness in the public eye of human rights as a modern culture, high profile incidents such as the violent killing of Jonathan Zito,³¹⁴ and the evidence of the inquiry that followed, have led to a substantial denigration of the rights of the mentally ill in the public's imagination. Headlines such as '*The tragic scandal of a schizophrenic killer that nobody stopped*'³¹⁵ reinforce the negative attitude held by many towards both mental illness and the care management of the mental health system itself. Consequently, continuing research indicates that attitudes towards individuals with mental illness have changed significantly in recent years,³¹⁶ with young people (16-34 year olds) more likely to have negative views than those in older groups.³¹⁷

For many older people, their perceptions are heavily influenced by the memories of the old local asylums, notably by the much-publicised reports of the 1960s and early 70s into abuse and neglect³¹⁸ with patients seen as helpless victims and staff as abusers. In a practical context, with the larger numbers of people then detained in local institutions,³¹⁹ many families would have had first-hand experience of a family member or friend being ill, and this

³¹³ ONS, Psychiatric Morbidity in Great Britain, 2000, Prevalence of Psychiatric Morbidity Among Adults Living in Private Households, London, 2001.

³¹⁴ www.zitotrust.co.uk Jonathan Zito (1965-1992).

³¹⁵ *The Independent*, 19.07.93.

³¹⁶ Scottish Executive. *Well, what do you think?* A national Scottish survey of public attitudes to mental, well-being and mental health problems. Edinburgh: Scottish Executive, 2002.

³¹⁷ Yarney, G. (1999) "Young less tolerant of mentally ill than old." *British Medical Journal*, 319, p. 1092

³¹⁸ www.whittinghamhospital.co.uk/#the%20inquiry The Whittingham Hospital Report, Cmnd. 4861 (February 1972): Whittingham Hospital, just outside Preston in Lancashire, had 3,200 beds in 1953 and 2,045 in 1971. It was one of England's largest mental hospitals, though shrinking as active psychiatry was moved to District General Hospitals in Preston. Allegations of ill-treatment and the conviction of a male nurse for the manslaughter of a patient, led to an inquiry, which reported that for many of Whittingham's patients the therapeutic revolution of the late 50s never happened. Almost half had no occupation during the day, but sat around "becoming cabbages". On one ward, 126 patients were cared for by just six nurses. Doctors did not visit long stay wards, but concentrated on acute work and their work outside the hospital. The inquiry concluded that the English mental health system was dividing into "well staffed 'acute' units and 'long stay dumps'".

³¹⁹ Such as Brookwood, Park Prewett, Colney etc.

perhaps goes some way towards explaining the consistently sympathetic attitude shown by the older generations. That such scandals occurred mostly in the hospital setting is reflective of a number of factors. The high number of long stay beds allocated to large asylums³²⁰ where the majority of care was long term and institutionally based; meant that discharge planning and risk assessment were almost non-existent, with little post discharge support available. People such as, Christopher Clunis, Michael Buchanan and Ben Silcock would have inevitably been kept in special hospitals for life; therefore incidents as such would not have touched the wider community, essentially a typical case of *out of sight, out of mind*, and very much *at arms length* away from the public gaze.

For the younger generations, the social context has changed markedly. In the sixties, the incidence of violent crime was relatively low; inflation, unemployment, and homelessness were marginal issues rather than the serious economic ills that were later to plague the 1970's. That the latter part of the twentieth century suffered from periodic recession and inflation with increased unemployment, poverty and homelessness is perhaps indicative of the modern culture-speak of urban decay and regeneration that typifies much of the popular media today. Conditions such as poor housing, inadequate access to health care, poor job prospects etc, all contribute to a low quality of social environment and are seen as risk factors that are potentially realised in part in increases in both mental illness and violent crime.³²¹ However, rather than viewing economic poverty as a singular factor, it is best explained as a relative deprivation. Even in times of robust economic growth when wealth and income increase generally, deprivation occurs if the gap between rich and poor increases.³²² Research has indicated a strong correlative effect between disadvantaged circumstances and mental health.

³²⁰ Park Prewett in Basingstoke consisted of 15 wards, housing 1200 patients and a further 100 in admissions. The asylum closed in 1996 and was converted to housing. <http://www.rooksdow.org.uk/parkprewett.html> Accessed 12 Dec 2008.

³²¹ Muijen, M. (1995) 'Scare in the Community: Part Five: Care of Mentally ill People' *Community Care*, (7-13 September), i- viii.

³²² Merton, R. (1937) 'Social Theory and Social Structure and Anomie' *American Sociological Review*, 3. 672-82. (Revised edn, Glencoe: Free press 1957).

Roger Gomm made the following concise observation:

“A very simple statement will serve to summarise all the research findings on this matter: for nearly every kind of illness, disease or disability, ‘physical’ and ‘mental’, poorer people are afflicted more than richer people: more often, more seriously and for longer – unless, of course, they die from the condition, which they do at an earlier age.”³²³

Suicide, which is now the second most prevalent cause of death among younger men,³²⁴ consistently shows a higher incidence among the low skilled, unemployed and homeless.³²⁵ Depression is also associated with a strong social class profile, the “less well off” you are, the more likely you are to be miserable and depressed.³²⁶ Self-harm which is often seen as a precursor to suicide also shows a strong social class correlation.³²⁷ Even so, the incidence of both mental illness and crime in any given circumstances is at best anecdotal outside of the relevant research context. Just as a large number of minor crimes go unreported; the majority of people with mental illness do not require acute treatment.

Nonetheless, the public’s perception of mental illness is increasingly identified with crime, violence, social deprivation and wide-scale policy failure, a discriminatory and stereotypical association that is often exploited in both political comment and press reporting. Understandably, following a number of high profile homicides by mentally distressed individuals of ethnic origin, there has been a tendency to further equate mental illness with minority identities, in

³²³ Gomm, R. *Mental Health and Inequality*, (editor) *Mental Health Matters, A Reader*, (1996), Basingstoke, Palgrave Macmillan, p.110.

³²⁴ In men aged 15-24 years the suicide rate rose from 9 per 100,000 population in 1979 to 13 per 100,000 in 1999; a rise of almost 50 per cent. Since 1999, the figures have shown a downward trend. Among men, the highest rate of suicide since 1997 has been in those aged 15-44 years. .ONS, 2007, *Mortality Statistics*, Series DH2 nos. 30 and 32.

³²⁵ Meltzer et al., (1995), *The prevalence of psychiatric morbidity among adults living in private households*, *OPCS Surveys of Psychiatric Morbidity in Great Britain*, Report 1, London, HMSO.

³²⁶ Cooper, R. Boyko, C. and Codinhoto, R. (2008), *The effect of the physical environment on mental well-being. Mental Capital and Wellbeing Project*. London: Government office for science, www.foresight.gov.uk/ourWork/ActiveProjects/Mental%20capital/Projectoutputs.asp. Accessed November 28th 2009

³²⁷ Gunnell *et al.* (1995), ‘The relation between parasuicide, suicide and psychiatric admission and socio-economic deprivation’ *British Medical Journal*, vol. 311, p.226-30.

particular, young Afro-Caribbean men,³²⁸ are often seen as dangerous by the authorities, (with or without mental health problems). That such marginalisation occurs has been blamed on a variety of factors, foremost of which are the difficulties that many ethnic minorities have in being able to access services,³²⁹ and when they do, there is evidence that amounts to a position of institutional racism.³³⁰

Policy-makers have, though somewhat belatedly, acknowledged that inequality exists. The Social Exclusion Task Force was set up in May 2006, aiming to build on the work of the Social Exclusion Unit, which was part of the Office of the Deputy Prime Minister. It's first report, *Reaching out: an Action Plan on Social Exclusion*,³³¹ set out cross departmental strategies to improve the lives of affected individuals and communities, with special measures aimed at challenging negative attitudes towards the mentally ill.

3.3 Case study 1 Christopher Clunis

Within the context of policy, media reporting and it's effect upon public opinion, there were two events that had a significant impact. The first of these was the killing of Jonathan Zito by Christopher Clunis and the second was the murders of Lin and Megan Russell by Michael Stone. Both cases received considerable media coverage that was critical of the community care system. The Clunis case is significant, as it prompted the first independent enquiry³³² into a murder committed by a mental patient whilst ostensibly under the care of both psychiatric and social services.

³²⁸ For further discussion, see - Browne, D. (1991), *Black people, Mental Health and the Courts: an exploratory study into the psychiatric remand process as it affects black defendants at magistrates court*, London, National Association for the care and Resettlement of Offenders.

³²⁹ NIMH, 2003, *Inside outside*, improving mental health services for black and minority ethnic communities in England, DH.

³³⁰ Harrison, G., 2002, 'Ethnic minorities and the Mental Health Act', *The British Journal of Psychiatry* 180: 198-199.

³³¹ The Cabinet Office, (2006), *Reaching out: an Action Plan on Social Exclusion*, 11.09.06 HMSO.

³³² Ritchie, J. Dick, D. & Lingham, R. (1994). *Report of the inquiry into the care and treatment of Christopher Clunis*. London: HMSO.

Newly married Jonathan Zito died at Finsbury Park tube station on the 17 December 1992 after being fatally stabbed in the eye by Christopher Clunis, a black Afro-Caribbean suffering from schizophrenia. Clunis, aged 29, had recently been released from hospital into the community.³³³

Following the death of Jonathan Zito, the initial coverage in the national press was to a certain extent incidental, warranting in most cases only a few paragraphs on the inside pages, with no photos or names given.³³⁴ During Clunis's trial, the media's initial concerns questioned as to why a schizophrenic with a past history of violence was being cared for in the community? Fostering the growing suspicion that public policy had failed, Though the question was reasonable in context, the media failed to address many wider social issues, it is significant that the coverage centred almost exclusively on what was seen as an excess of freedom enjoyed by Clunis, running headlines such as "*Killer who roamed free*"³³⁵ and "*The tragic scandal of a schizophrenic killer that nobody stopped*".³³⁶ For example, the Daily Mail's reporting of the Clunis trial placed a great deal of emphasis on comments made by Jane Zito, with the leader, "*Why was he set free to kill my husband*"³³⁷ Later coverage became more detailed with several parallels being made between Jonathan and Jayne Zito both white middle class professionals and Christopher Clunis a mentally ill, young, Afro-Caribbean man. Jayne, who had been employed in the field of mental health, was portrayed as the "dignified widow who bears no hatred,"³³⁸ while Christopher Clunis as the "psychotic knifeman,"³³⁹ black, from a deprived background and with a history of violence. The Independent newspaper reported on its own in-depth investigations of "*events that led to a random killing.*"

³³³ Briefly discussed in Chapters One and Two.

³³⁴ "Tube Man Dies in Knife Attack" *The Daily Mirror* 18.12.92, "Knife Death Terror at Tube Station" *The Daily Mail* 18.12.92.

³³⁵ *Evening Standard* 30.06.93.

³³⁶ *The Independent* 19.07.93.

³³⁷ *Daily Mail*, 29.06.03.

³³⁸ *The Independent*, 19.07.93.

³³⁹ *Evening Standard*, 30.06.93.

A constant feature of the articles was that responsibility for Christopher Clunis was constantly transferred with little to no co-ordination between geographical areas, between doctors, social workers and psychiatrists, a theme which is reflected in its headline "*Passing the buck until an innocent man died*".³⁴⁰ In identifying such issues, the press agenda focused not only on the question of the freedom allowed to Christopher Clunis and the disjointed care that he had received, but expressed considerable disbelief as to how a state of affairs occurred in which a large, powerfully built, young, violent, mad black man had been overlooked by both the psychiatric services and the criminal justice system. The Media's concerns at how such a horrific event could have occurred in such an every-day urban setting became in essence a populist campaign, with the emphasis shifting from the subjective focus accorded to the central characters (Jonathan and Jayne Zito and of course Clunis himself) to wider questions that cast doubt on the quality and competence of mental health care services working in the community.

As a consequence of such widespread reporting in which public anxiety grew to be increasingly self-evident, Virginia Bottomley the then Health Secretary ordered an official inquiry into the care and treatment given to Clunis by the psychiatric services.³⁴¹ What emerged was described as a "*catalogue of failure and missed opportunity*",³⁴² The report, which ran to 146 pages, stated in its conclusion that psychiatrists, social workers, the Crown Prosecution Service, and the Probation Service must all share the blame for the tragedy.³⁴³ The inquiry found that "the more disturbed Christopher Clunis became, the less effective was the care he received."³⁴⁴ Clunis was known to be violent and to carry knives yet not one of the 43 different psychiatrists who saw him over a four-year period had seen a full and accurate copy of his medical and criminal records. Clunis was discharged from nine psychiatric units in five years.

³⁴⁰ *The Independent*, 19.07.93.

³⁴¹ Ritchie, J. Dick, D. & Lingham, R. (1994). *Report of the inquiry into the care and treatment of Christopher Clunis*. London: HMSO.

³⁴² Court, C. *BMJ* 1994;308:613 (5 March).

³⁴³ The Clunis Inquiry heralded the introduction of supervised discharge orders (1996).

³⁴⁴ *Op. cit. Conclusion*.

The official report found that Clunis had stabbed at least two people and attacked several others before he killed Jonathan Zito. The inquiry, chaired by Jean Ritchie QC also found that a lack of cash for care played a key part in the tragedy, and that care policies and agencies must share blame for mistakes that ended in the death of Jonathan Zito. On a more public note, the reporting of the death of Jonathan Zito prompted a change in public attitudes, where the concerns about the welfare of many was replaced by fear of the risk posed by the few.³⁴⁵

The Clunis case is still seen as an archetypal index, retaining an enduring if somewhat haunting impact in populist and policy agendas. What is more disturbing is the way in which the media portrayed Christopher Clunis as a racialised stereotype (black, male, powerful) to the degree that the conceptual amalgam of insanity and racial type has effectively established itself in the practices of various organisations such as the police³⁴⁶ and psychiatric services. A recent publication by the Care Quality Commission found that of all the patients detained under s3 MHA, rates were higher than average among the Black Caribbean, Other Black and White/Black African Mixed groups by 30%, 27% and 44% respectively.³⁴⁷ African-Caribbean and South Asian people are diagnosed with a major psychotic illness at five times the rate of the general population and 60% of black people enter psychiatric hospitals via Section 136 of the Mental Health Act compared to 10-15% of the general population.³⁴⁸ As one ex in-patient remarked when interviewed:

“When I was in hospital it seemed social workers brought in new white patients, but black patients were usually brought in by the police and shoved in lock-up wards”³⁴⁹

³⁴⁵ Laurance, J. *Fear is the worst way of managing mental health*, The Independent, Tue 19th November 2002.

³⁴⁶ Macpherson Report (February 1999), Cm 4262-I. The inquiry headed by Sir William Macpherson examined the original investigation into the murder of Stephen Lawrence and concluded that the force was institutionally racist.

³⁴⁷ Care Quality Commission, *Count me in 2009: Results of the 2009 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. The rates of detention under section 3 are given in Appendix B, Table B8.

³⁴⁸ Sashidaran, S. & Francis, E. (1993) *Epidemiology, Ethnicity and Schizophrenia* in Ahmed, W. (ed) *Race and Health in Contemporary Britain*. Buckingham: Open University Press. p. 3.

³⁴⁹ J. & Baker, S. (1996), *Not just sticks and stones*, Mind.

3.4 Case study 2: Michael Stone

Michael Stone, a drug addict with a severe personality disorder, is currently serving three life sentences in Wakefield prison for the murders of Lin Russell and her six year old daughter Megan, in an apparently motiveless and unprovoked attack as they walked down a country lane in Kent in 1996. Megan's sister, Josie, then aged nine, was severely injured and left for dead.

There were many failings in the care Stone received, but even if they had all been remedied, the inquiry³⁵⁰ found there was no guarantee that things would have turned out differently. The 384-page document said there was no suggestion that Stone was deprived of any service, which would have made him less of a danger to the public. In its conclusion, the inquiry identified a number of failures by the mental health services, social services, drug addiction services, and the probation services. However, they also stated the following:

The challenge presented by a case such as Michael Stone's is that his problems are not easily attributable to a single feature of his condition or to combinations of them. Further, he did not easily fall into the province of one agency or a combination of them. His problems were multi-factorial, and constantly changing in their presentation and importance. While at times there will be things that can be done for such a person to reduce any dangers he may pose to the public and to help him cope, at other times there will be little that can be offered by any of the services.³⁵¹

The report was completed in 2000, but publication was delayed for legal reasons, Stone has recently lost a further appeal against his conviction.³⁵² Stone is now serving three life sentences and has been told he must serve at least 25 years in jail over the 1996 attacks in Chillenden, Kent.

³⁵⁰ Francis, R. QC, '*Report of the independent inquiry into the care and treatment of Michael Stone*,' September 2006, South East Coast Strategic Health Authority, Kent County Council, Kent Probation Area.

³⁵¹ *Ibid.*, pp.8-9.

³⁵² Michael Stone was refused a new appeal over his conviction for the murders of Lin and Megan Russell, the Criminal Cases Review Commission (CCRC) stated today. *The Independent*, Tuesday, 26 October 2010

Both the Christopher Clunis and Michael Stone cases identified many shortcomings that seemed to be entrenched within the system at the time. Clunis had a long police record of violence, a fascination with knives, had been known to miss outpatient appointments, and had on several occasions stopped taking his medication. After seeing 43 psychiatrists in four years Christopher Clunis was discharged into the community, where the community follow-up was deemed by the report to be less than satisfactory. Unlike Michael Stone, he had paranoid schizophrenia, an illness which responded well to medication, however, no-one seemed to know that he had stopped taking his medication. Social services had in fact left a card on his doormat while he was already on the way to Finsbury Park, where he stabbed Jonathan Zito.³⁵³ Although the report, in view of Christopher Clunis's past history, was unable to determine if Jonathan Zito's death was avoidable, it left little doubt that the lack of adequate after-care and the failure of the various agencies involved to participate cohesively in a structured care plan, were undoubtedly contributory factors in treating a potentially dangerous patient with schizophrenia, a condition that generally responds well to medication.

Michael Stone had a series of serious criminal convictions for violent assault and armed robbery, coupled with a history of serious drug abuse. However, Stone was diagnosed as having a serious personality disorder and as such was deemed untreatable and therefore not eligible to be detained in hospital, despite the misgivings of several of the psychiatrists that had 'seen' him. Perhaps if he had been able to be sectioned³⁵⁴ when seeking help, he may not have murdered Megan Russell and her mother.

Both cases resulted in the horrific deaths of innocent strangers and despite having been the subject of considerable negative reporting by the media, each case has proved to be the catalyst for further reform. Following Clunis, it

³⁵³ Ritchie, J. Dick, D. & Lingham, R. (1994). *Report of the inquiry into the care and treatment of Christopher Clunis*. London: HMSO.

³⁵⁴ As is now the case under the new 2007 MHA, with its broader definition of mental disorder and the Code of Practice's guidance regarding 'appropriate treatment'.

is now mandatory that an inquiry is held following any case of homicide where a mentally ill person is involved.³⁵⁵

The case of Stone highlighted an apparent lacuna within the criteria for detention and treatment under the MHA. Under the old Act, detention powers rested on the patient falling within the scope of the narrow definition[s] of mental illness, psychopathic disorder, mental impairment and severe mental impairment as set out in s1(2) and that he met the “treatability test” as defined in s3(2)(b): that the disorder was of a nature or degree which made it appropriate for him to receive medical treatment in a hospital.³⁵⁶ This somewhat restrictive definition of treatment led to cases where some people with borderline personality disorders were released or remained in the community despite being dangerous to others, because their conditions weren’t considered treatable. If it is not treatable, so the argument follows, then they shouldn’t be in a hospital. Conversely, increasingly within the media and some sections of the psychiatric profession, there had been considerable misgivings as to deep-seated flaws that appear with recurring regularity within the system regarding questionable decisions to release patients into the community on the basis of treatability alone.³⁵⁷

Under the new 2007 Act, the treatability test is replaced by the concept of “appropriate treatment”, which gives a broader interpretation of what amounts to the available treatment required before the detention of such individuals.³⁵⁸ Although there has been considerable criticism that reforms to the old treatability requirement under section 3 of the 1983 Act (now the appropriate treatment requirement) could allow for the unwarranted detention of people who may potentially be a danger to others or themselves, but as yet had not

³⁵⁵ Department of Health (1994).

³⁵⁶ Amended by s3(2)(d), appropriate medical treatment is available for him & s3(4) In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case.

³⁵⁷ Muir, H. & Taylor, D. The Guardian, 15th March 2006. *Tragic waste; Inquires into violent crimes committed by mentally ill people are often held internally, But critics claim vital lessons are being missed.*

³⁵⁸ Section 4 of the 2007 Act introduces a new “appropriate medical treatment test” into the criteria for detention under section 3 of the 1983 Act, related sections of Part 3 and the corresponding criteria for renewal and discharge.

committed any offence. It is equally arguable, that despite a number of misgivings concerning 'unwarranted detentions',³⁵⁹ the broader notion of 'appropriate treatment' under Section 4 of the 2007 Act has recognised the necessity for making treatment available for the small number of people, that otherwise would have been excluded under the 1983 Act.

3.5 Inquiries, the media and the public

Following the Clunis case, inquiries into homicides committed by people with mental health problems were made mandatory through an NHS Guidance paper.³⁶⁰ Although it is undoubtedly the intention for such inquiries to identify the failures that arise from such events, and how best to address those issues; media reporting has tended to focus on inexplicably motiveless acts of violence committed by people who are mentally ill rather than any of the positive aspects that come out of the inquiry process. Subsequently there are real concerns that the media's approach to the reporting of inquiries and the events that precede them is fostering a latent function of apportioning blame, largely to appease 'public opinion disquiet'.³⁶¹

When viewed from such a persuasive, (*pervasive*) platform, it is hardly surprising that the public have come to see inquiries and the reporting of them as an exercise in hindsight, seldom fulfilling public expectations. As Muijen States:

'Inquiries are time consuming and costly. Psychiatrists and social services were increasingly identified with neglect and poor judgment...Staff are subjected to intense scrutiny, undermined by a culture of attribution and of guilt if unpredictable events occur... that responsibility across as well as within agencies were unclear, communications appalling, risk assessment unsatisfactory and re sources inadequate. Almost invariably they also conclude

³⁵⁹ Press Release, Mental Health Alliance, 17 November, 2006: "The Government argues that requiring a person to be 'treatable' before they are detained is a major loophole in the Act, but there is no evidence that this is the case. Health legislation should not be used to impose treatment that has no benefit on a patient under compulsion. What matters most is that people with mental health problems have access to decent services that work well."

³⁶⁰ Department of Health (1994).

³⁶¹ Eastman, N. (1996). Towards an audit of enquires. In Peay, J. (ed.) *Inquires after Homicide*. London Duckworth. p. 157.

that the incident could not have been attributed to failings of individual managers or clinicians.³⁶²

While inquiries seem to officially acknowledged evidence of failure, with an underlying tendency to engage in retrospective justification, from a media perspective, they have a tendency to reinforce the public's anxieties of the effectiveness of care in the community. Understandably, many members of the public see homicide inquiries as a less than impartial mechanism in apportioning blame.

Following the conviction of Ismail Dogan,³⁶³ for manslaughter and wounding, the media questioned the usefulness of the inquiry system over concerns as to how Dogan's case would be reviewed after The Haringay Teaching Primary Care Trust announced that it would be examining the affair by way of an internal inquiry stating that:

"it is not obliged to hold an independent inquiry because Dogan was being treated by his GP and was not a patient directly under its care. It means that no external investigation will take place unless the strategic health authority rules otherwise. "Hopefully, they will find that an independent inquiry won't be necessary,"³⁶⁴

There is however long-term evidence that some elements of the press have taken on a more responsive role. That there have been issues with the negative bias shown by some editors has not gone unnoticed or unreported. In an article in *The Guardian*, 'Out of the bin and glad to be mad,' the author addresses the subject of inconsistent media reporting by stating some obvious home truths:

"Start with the scary statistic that someone is killed by a mental patient every fortnight. It sounds like confirmation of the psycho-killer myth – but it hardly survives scrutiny. For the roughly two-dozen homicides by mental patients are a tiny fraction of the nearly 700 murders

³⁶² Muijen, M. 'Inquires: who needs them?' *Psychiatric Bulletin* 1997, 21:132-133.

³⁶³ Old Bailey, March 2006. In June 2004 Ismail Dogan stopped taking medication to control his paranoid schizophrenia. Six months later he ran amok in north London, killing one man and seriously injuring five other people after hearing the "voice of God" in his head telling him to stab people.

³⁶⁴ Muir, H. & Taylor, D. Tragic Waste: Critics claim vital lessons are being missed, *The Guardian*, Wednesday 15 March 2006.

in Britain every year. Tabloid tales of 'crazed killers' are statistical flam, designed to tap into a deep and ancient fear of the lunatic: mad, bad and dangerous."³⁶⁵

On September 23rd 2003, the Sun newspaper led with a headline that labelled former heavyweight boxer Frank Bruno as "bonkers".³⁶⁶ In the first edition of the paper the front page leader read "Bonkers Bruno Locked Up" above a story that stated that he was "violent and a nut", bringing a deluge of protest from both readers and mental health charities. Realising it had misjudged the public mood, the Sun's then editor, Rebekah Wade, was forced into a climbdown, changing the headline in later editions to read, "Sad Bruno in Mental Health Home", with the accompanying story calling him a "National hero".

In a press release, Marjorie Wallace, the chief executive of the mental health charity Sane stated that:

"It is both an insult to Mr Bruno and damaging to the many thousands of people who endure mental illness to label him as 'bonkers' or 'a nutter' and having to be 'put in a mental home', "...
"Such ignorant reporting does both the media and the public a huge disservice."³⁶⁷

That so many readers had reacted so vehemently to the Sun's article is perhaps an indication that there was a growing body of public opinion opposed to sensationalist or spurious reporting, particularly when the person concerned was regarded as a national institution, however, the question of who is 'mad' or who is 'bad' remained for the most part with the press.

Though perhaps a little cynical, there is undoubtedly some truth in the old adage that 'news sells newspapers'. Nonetheless, the effect of such negative media reporting is not only problematic from a public standpoint; it often exerts a considerable amount of influence politically.³⁶⁸

The concern over the impact of mass media reporting of inquiries on public opinion, and the latent responsibility that it implies towards policy, has been

³⁶⁵ James Foreland, 21 Jan 1998, 'Out of the bin and glad to be mad', *The Guardian*.

³⁶⁶ The Sun, 23rd September 2003.

³⁶⁷ The Guardian, 23rd Sept 2003.

³⁶⁸ Department of Health, (1998a), *Modernising Mental Health Services: Safe, Sound and Supportive*, London: The Stationery Office.

the subject of considerable research, the relationship is complex; although media itself does not create society *per se*, it can generate strong beliefs and responses in its recipient audience that often produce an emotional operative effect. In *Paper Voices*, Stuart Hall argued that:

“Our starting point was the assumption that at all times, but especially in periods of rapid social change, the press performs a significant role as a social educator. By its consistent reporting and comment about people and events, the press reflects changing patterns of life in society. More significantly, by its selectivity, emphasis, treatment and presentation, the press interprets that process of social change.”³⁶⁹

However, it is perhaps the nature of such selectivity that is problematic, in reporting adverse events such as homicides by the mentally disturbed, the press takes on the role of an ‘active text’ within the complex interplay between policy and public opinion. While policies such as ‘Care in the Community’ and the CPA emphasise integrated approaches, a key issue in media reporting to the public is the potential for ‘moral panic’ in response to such policies.³⁷⁰ Though it is perhaps simplistic to claim that individual members of the public are grossly affected by mass media imagery, there is some research that indicates that mental illness and the mentally ill when viewed by the public through the media lens, instil an uncertainty, sometimes bordering on fear,³⁷¹ potentially fostering alienation and stigmatisation in opposition to public policy.

3.6 Educating the Public about mental illness.

In the aftermath of Clunis/Zito case, the Glasgow Media Group published a report following research on the media’s coverage of mental illness.³⁷² The research methodology used was based on content analysis and audience response over a period of one month (April 1993). The samples for content analysis included factual formats such as press reports, media comment and

³⁶⁹ Hall, S. (1975), “Introduction” in Smith, A. H. *Paper Voices: The Popular Press and Social Change*, London, Chatto & Windus, p.11.

³⁷⁰ Muijen, M. (1995) ‘Scare in the community: Part Five: Care of Mentally Ill People ‘ *Community Care*’ (7-13 September, I-viii).

³⁷¹ Philo, G. *etal* (1994) The Impact of Mass Media on Public Images of Mental Illness: Media Content and Audience Belief, *Health and Education Journal*, vol. 53, pp. 271-281.

³⁷² *Ibid.*

analysis, current affairs programmes and problem pages in magazines. The study also considered the impact of fictional formats such as comic strips, soap operas, drama productions and films. The findings indicated that the samples considered could be generalised into five distinct categories: violence to others, sympathetic coverage, harm to self, comic images and criticisms of accepted definitions of mental illness.³⁷³ Items that linked mental illness and crime outweighed sympathetic reporting by a ratio of almost four to one. However, the authors admit that such figures are open to interpretation as some items, often displaying exaggerated violence, tended to be given a high profile in the media, whilst other more sympathetic perspectives were confined almost exclusively to background writing in health features in newspapers and the problem pages in magazines.³⁷⁴

The research indicated that the impact of the media and particularly soap operas were major factors in helping to form opinions of the participants as to what it means to be mentally ill. One audience participation exercise showed a *vignette* from *Coronation Street*'s 'Carmel' story line that featured an attractive young Irish nurse who initially appeared to be a fresh-faced fun-loving girl. However as the plot unfolded it emerged that behind the angelic façade, there was an intensely destructive character with serious irrational obsessions. When shown stills from the story line, the participants exhibited a dramatic response indicating recognition and animosity, with a large number of those participating being able to recall the accompanying dialogue with startling accuracy even though it was several months after the episodes had been broadcast.

One of the key issues the participating groups considered was whether mental illness was always associated with violence. Around two-thirds of the respondents believed that the two were strongly connected, while approximately two-fifths of those interviewed indicated that both fictional and

³⁷³ Philo, G. *et al.* (1994) The Impact of Mass Media on Public Images of Mental Illness: Media Content and Audience Belief, *Health and Education Journal*, vol. 53, p. 273.

³⁷⁴ For the most part women's magazines such as *Cosmopolitan*, *Women's Own* etc with marginal or non-existent coverage in men's magazines such as *Men's Health*, *GHQ* etc (don't men suffer from mental illness or perhaps they just don't like to talk about it!).

factual sources in the media had influenced their beliefs. As one of the respondents put it:

“A lot of things you read in the papers and they’ve been diagnosed as being schizophrenic. These murderers – say Donald Neilson, was he no schizophrenic? – The Yorkshire Ripper...in Brookside that man who is the child abuser and wife beater – he looks like a schizophrenic – he’s like a split personality, like two different people.”³⁷⁵

There is however some evidence by participants who rejected the view that the media was influential in affecting their personal beliefs, that they felt that they had based their opinions on their own personal experiences relative to their own circumstances or those of a family member or friend. However, some of the participants (21% of the sample), even though they had not personally had any direct experience of violence, felt that the media had heavily influenced their judgement of the issues. One young woman who lived near a psychiatric hospital stated that:

“The actual people that I met weren’t violent – that I think they were violent comes from television, from plays and things. That’s the strange thing – the people were mainly geriatric – it wasn’t the people you hear of on television. Not all of them were old, some of them were younger. None of them were violent – but I remember being scared of them, because it was a mental hospital – it’s not a very good attitude to have but it is the way things come across on TV, and films – you know, mental axe murderers and plays and things – the people I met weren’t like that, but that is what I associate them with.”³⁷⁶

Though the Glasgow Media Group’s research (1994) has been the subject of a certain amount of critical discussion relating to sample population size, duration of the study and outside variables, such as the survey being carried out in the wake of the high media profile Clunis/Zito storyline, nonetheless, it would be difficult to argue its validity extrapolated to a more general population (an inherent criticism in most methodologies). In general its findings parallel earlier and often replicated research into public opinions and

³⁷⁵ Philo, G. *et al* (1994) The Impact of Mass Media on Public Images of Mental Illness: Media Content and Audience Belief, *Health and Education Journal*, vol. 53, p. 275.

³⁷⁶ *Ibid.*, p. 276.

prejudices such as the CAMI scale³⁷⁷ and more recent research such as Huxely's *et al* evaluation of attitudes towards mental illness in UK schools.³⁷⁸

Research into media attitudes carried out in other countries has drawn similar conclusions. For example In the *Medical Journal of Australia*, Hocking argues that:

"Educational campaigns aimed at people in the community and media personnel could help demystify mental illness and reduce the portrayal of offensive stereotypes of people with schizophrenia...two important ways of doing this are improvement in mental health literacy and stopping the constant reinforcement of stigma by the media."³⁷⁹

Similar studies have been carried out in other countries with comparable findings.³⁸⁰

In response to negative attitudes portrayed in the media, a number of agencies have introduced positive measures to actively combat the stigmatisation and social exclusion of mental health service users. North of the border, the Scottish Executive published its second national survey of public attitudes to mental health, *Well? What Do You Think?*³⁸¹

The report indicated that following a number of educational initiatives, significantly the Scottish Executive's 'See Me' national anti-stigma campaign, public attitudes towards the mentally ill had shown a positive improvement when compared to earlier surveys. In the words of the report:

"While it is difficult to be certain what has brought about these changes, and too early to be confident that they represent a long-term trend, it seems likely that the work of the National Programme and, in particular, the 'See Me' campaign has helped to reduce some of the

³⁷⁷ Wolff, G. Pathare, S. Craig, T and Leff, J. 'Community Attitudes to Mental Illness' *The British Journal of Psychiatry* 168: 183-190 (1996).

³⁷⁸ Huxely, P. Farmer, B. & Graham, T. 'Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools' *The British Journal of Psychiatry*, (2003), 182, pp. 342-346.

³⁷⁹ Hocking, B. (2003), 'Reducing mental illness stigma and discrimination – everybody's business,' *Medical Journal of Australia*, Vol 178 2003, pp.47-48.

³⁸⁰ Coverdale, J, Nairn, R. & Classen, D. (2002) 'Depictions of mental illness in print media; a prospective national sample' *Australian and New Zealand Journal of Psychiatry* Vol. 36, No. 5. p. 697

³⁸¹ Scottish Executive. (2004) *Well? What Do You Think?* The second national Scottish survey of public attitudes to mental health. Edinburgh: Scottish Executive.

stigma surrounding mental ill-health. The fact that 72% of respondents said that they were aware of the recent promotional activity indicates that, at the very least, messages appear to be reaching the majority of the population.”³⁸²

The Campaign itself, though originally a central government concept, through a robust marketing initiative³⁸³ was expanded to include health groups, local authorities, NGO's and local businesses across Scotland, with continuously ongoing revision helping to evaluate the progress of the campaign. That 'See me' was able to operate effectively at both national and local levels is arguably an example of shared empowerment that has resulted in many of the local initiatives integrating service users into key roles to address local issues and target specific groups. One of the key aims was for 'See Me' to provide a resource base for media professionals by recruiting service users who had experienced stigma to act as 'media volunteers' to assist and advise the media in combating what was seen as latent stigmatisation; a pilot scheme that was seen as an innovative method of getting the media to reflect the reality of stigma to a wider target audience. In order to reach the public eye, an advertising campaign on Scottish TV focused attention on the arbitrary use of diagnostic terms with the slogan 'See Me...I'm a person not a label. The advert notably featured a goalkeeper wearing the colours of a well known Glasgow team on his goal line with 'Schizophrenic' on the back of his shirt instead of a name. With football as a national pastime having a popular place in the public's imagination, the impact of the campaign touched even hardened cynics in the Scottish media.³⁸⁴

More recently, Shift³⁸⁵, a Government consultation programme to reduce this stigma and discrimination, commissioned a survey of media coverage to establish whether changes in reporting could improve the lives of people with

³⁸² Scottish Executive. Well? What Do You Think? 2004: the second national Scottish survey of public attitudes to mental health. Edinburgh: Scottish Executive. www.scotland.gov.uk/socialresearch.

³⁸³ The professional communications agency CitigateSMARTS was chosen from a number of invited tenders to provide a comprehensive design and deliver package to support the campaign team.

³⁸⁴ Duncan, L. & Gordon, L. Tackling The Attitude Problem, *Mental Health Today*: Brighton, Pavilion Publishing March 2005 pp. 22-25.

³⁸⁵ Shift was initiated by the National Institute for Mental Health in England (NIMHE). www.shift.org.uk/.

mental health problems.³⁸⁶ Significantly, the survey included considerable input from the media world itself; in the foreword, Jeremy Dear, the General Secretary of the National Union of Journalists stated:

“Stigma blights the lives of far too many people experiencing mental ill health. The media has a vital role to play in helping reduce this stigma and improving people’s understanding of mental illness.”³⁸⁷

Undoubtedly, there has been a noticeable *shift* in policy, media and public appreciation of the wider issues that affect the mentally ill. The Press Complaints Commission now reviews its own code of practice on an annual basis, with the 2008 Annual report specifically targeting clauses 5 and 12.³⁸⁸ Though self regulatory, in the 2008 PCC Review³⁸⁹ Sir Christopher Meyer in the foreword, reflected that though not perfect in an ideal world, the PCC had undoubtedly raised the standards of editorial responsibility.³⁹⁰

Many NGO’s and Charities have also recognized the importance of educating the public; Mind, a leading UK charity is collaborating with a number of other organizations in *The-Time-to-Change* program in approaching the fight against discrimination and stigma by staging a series of events and road-shows around the UK that aim to engage public misconceptions about mental health through interactive participation.³⁹¹ Furthermore, World Mental Health Day, supported by all the leading Charities and NGO’s is now an annual event every October.³⁹²

That there is a need for wider policy change in stepping away from the existing pathway approach³⁹³ is reflected by the Government’s current public

³⁸⁶ Mind Over Matter: Media Reporting of Mental Health, CSIP/shift, Jan 2006, Sainsbury Centre for Mental Health, London.

³⁸⁷ Mind Over Matter: Media Reporting of Mental Health, CSIP/shift, Jan 2006, Sainsbury Centre for Mental Health, London.

³⁸⁸ Clause 5. Intrusion into grief or shock, Clause 12, Discrimination.

³⁸⁹ http://www.pcc.org.uk/assets/111/PCC_Ann_Rep_08.pdf Accessed 12.07.09.

³⁹⁰ *Ibid.*, p.5.

³⁹¹ <http://www.time-to-change.org.uk/> (accessed 12.07.09).

³⁹² World Mental Health Day, 10 October, <http://www.bbc.co.uk/headroom/> (accessed 10th October 2009).

³⁹³ Pierson, P. (2001) *The New Politics of the Welfare State*; Oxford, Oxford University Press.

consultation proposal; *New Horizons: Towards a shared vision for mental health*,³⁹⁴ which aims to continue the progress started by the NSF³⁹⁵ whilst acknowledging the need for change in policy. As part of its extensive remit the consultation intends to tackle discrimination and public perceptions of mental health through multi-disciplined initiatives working across Government, voluntary organizations the media and private sector stakeholders.³⁹⁶

3.7 Conclusion

The relationship between policy, the media and mental health has undoubtedly impacted on the public's perception of what it means to be mentally ill. Prior to the introduction of community-based care, most print media surrounding mental health was limited to reporting abuse cases in the older asylums and psychiatric institutions. For the general public, unless they were directly affected, mental health legislation and policy was for the most part '*at arms length*'. Only with the closure of the old asylums, the onset of community care and a number of high profile homicides, which received extensive media coverage, did mental illness become public property. The realisation that there was the possibility that potentially *dangerous people* were out on the streets, as robustly reported in the media, served to nourish the latent *urban folk mythology* created in popular cinema and literature. In the Glasgow Media Group study, researchers found that the way that many members of the public interpreted real news stories, was by referring to elements derived from fictional sources, particularly dramatic news images and widely seen feature films. In this way fiction was used to interpret facts. Additionally, the apparent failure of inquiries into homicides committed by psychiatric patients to produce any meaningful changes in the way in which patients are cared for and managed in the community, has again been the subject of considerable reporting by the press, with a corresponding effect on the public's concerns over mentally ill patients at large in the community.

³⁹⁴ New Horizons, Department of Health, 29620 1p 3k July 09, DoH.

³⁹⁵ National Service Framework for Mental Health, (NSF) 1999.

³⁹⁶ New Horizons, Department of Health, 29620 1p 3k July 09, DoH. How we will get there, p.97.

That there has been such a measure of success in taking on public attitudes in Scotland is for the most part due to the recent reforms of the Scottish mental health regime. Following the Report of the Millan Committee,³⁹⁷ social exclusion and stigmatisation were identified as primary concerns in addressing public confidence in the system. As a consequence, such initiatives were robustly addressed in the new Scottish Mental Health Act.³⁹⁸ South of the border, Westminster has been less than enthusiastic in embracing the social ethos adopted by its northern neighbour. Since the Richardson Committee's findings,³⁹⁹ the need for a comprehensive review of the mental health system as a whole, and public confidence in the system in particular has been acknowledged, albeit with a certain amount of parliamentary reservation. With one Draft Mental Health Bill⁴⁰⁰ previously deadlocked, Health Minister Rosie Winterton's announcement that the 2004 Bill was to be scrapped and a new shorter amendment to the existing legislation would be considered in its place⁴⁰¹ was at the time derided by the press. Tabloid news leaders such as: "Chaos over plans to protect public from dangerous psychopaths",⁴⁰² did little to reassure public confidence.

Though there has been a considerable amount of research into the public's perception of mental illness, it is an area that understandably is difficult to quantify with any certainty. What has emerged however, is that from research projects such as that carried out by de Lima and Howell,⁴⁰³ and others, a large number of members of the public were unable to differentiate between mental illness and learning disabilities and there was little sympathy for people with depressive disorders who had tendencies towards suicide or self-harm. However, recent initiatives such as Shift's '*What's the story*',⁴⁰⁴ recognise the importance of media involvement in influencing public thinking.

³⁹⁷ Scottish Executive, New Directions: review of the Mental Health (Scotland) Act 1984, Report of the Millan committee 2001.

³⁹⁸ Mental Health (Care and Treatment) (Scotland) Act 2003 (Modification of Enactments) Order 2005.

³⁹⁹ Review of the Mental Health Act 1983, November 1999, London: HMSO.

⁴⁰⁰ The Draft Mental Health Bill 2002.

⁴⁰¹ Hansard, 23 Mar 2006 : Column 30 WS.

⁴⁰² James Slack, Home Affairs Editor, *Daily Mail*, March 24, 2006.

⁴⁰³ de Lima, A. & Howell, M, 'Tackling Them Young', *Mental Health Today*, Dec 2004-Jan 2005, 30-

32 Brighton, Pavilion Publishing.

⁴⁰⁴ www.shift.org.uk.

Following the apparent success of the Scottish Parliament's initiatives in combating stigma, England and Wales adopted Labour's *New Horizons* consultation process in the first instance, followed by the Tory and Liberal Democrats Coalitions election win, the *No health without mental health* ⁴⁰⁵ document as the way forward, acknowledging that the greatest difficulty to be overcome in re-constructing what has come to be seen as institutionalised social exclusion is the importance of improving the public's mental health literacy at a grass roots level and preventing the stereotypical reinforcement of stigma by the media.

The next chapter will consider mental health regulation from the perspective of those who are most affected, that is, the service users themselves.

⁴⁰⁵ *New Horizons* and *No Health without mental health* are more fully discussed in chapter five.

Chapter 4: Service users and the Mental Health System.

Introduction

In contrast to today's rights culture, the 1983 Act was drafted largely without any direct involvement from those to whom the legislation would apply. There were for most part very few organisations that could legitimately claim to represent patients' best interests and as a consequence service users had little or no voice in any significant consultative capacity. Although the influence of service user orientated organisations is on the increase, as demonstrated by the Mental Health Alliance in the recent consultative process leading up to the MHA 2007, the general overview is still one of legislative and medical paternalism. There is undoubtedly an inconsistency in recognising that people with mental health issues are entitled to be treated as empowered consumers as much as any other citizen. Arguably, they are for the most part held in less regard today than they were in 1983 at the inception of the Act. Despite the activities of the many action groups in existence today, most people with mental illness are still seen as potentially dangerous and stigmatized as socially inferior. Recent amendments introduced by the 2007 Act, (with a few exceptions), continue to maintain security and risk as the prevailing factors with access to better engagement with services as secondary considerations. For example, the introduction of Supervised Community Treatment Orders (CTO's),⁴⁰⁶ has from a service users point of view, combined an emphasis on risk surveillance and coercion with acquiescence to treatment by 'responsible service users'.⁴⁰⁷

The first part of this chapter considers the difficulties experienced by service users and other stakeholders relative to their positions as actors in what is perceived to be the primary function of mental health regulation. The aim here is to illustrate that from a service users perspective, there are some

⁴⁰⁶ MHA 2007, Amendments, s.17(A), replacing MHA 1983, s.25 (A) supervised discharge.

⁴⁰⁷ Mind, (Briefing 2. Supervised Community Treatment, 2007). Many people consulted by Mind felt that their relationships with professionals would be harmed by the increased threat of compulsion with those professionals being turned into "Mental Health Act police officers". They feared that the new measures would increase their chances of being subject to compulsion if they disagreed with the treatment recommended by their psychiatrist.
http://www.mind.org.uk/help/rights_and_legislation/briefing_2_supervised_community_treatment

fundamental issues that the current rationale within the existing care structure fails to address. Arguably, much of the implementation of the MHA today is affective rather than effective and falls short of what is required by service users for any semblance of a cohesive service.

This chapter will discuss the adverse effects the legislation has on those to whom it is primarily directed, the service user. How on one hand, such effects have contributed towards institutional entrenchment by the psychiatric profession, whilst on the other, have in practice provided only limited protection for the individual. At a subjective level the discussion will consider the real effect of the doctor patient relationship when viewed in context.

The second part of the chapter will consider some of the issues raised in section one from the perspective of service users' personal experiences of discrimination, disability, and the implications for social exclusion. It will also consider how a social model of disability can be used as a potential policy in gaining Social rights. The final section will consider whether in-patient care and subsequent discharge procedures are seen as therapeutic or detrimental from the service users perspective.

4.1 The service user.

Over 1.25 million people used the NHS mental health services in 2010, representing access rates of around 2,700 per 100,000 of the population, the highest number of individuals since data collection began.⁴⁰⁸ Of those 2,700, 76 percent will visit a GP, 33 percent will be diagnosed as having a mental health problem, 8 percent will be referred to a specialist psychiatric service and 2 percent will become inpatients in a psychiatric hospital. Of those who spent time hospital 39.4 percent were detained there under the Mental Health Act, a 30.1 per cent rise in the number of people detained in the previous year, rising from 32,429 in 2008/09 to 42,479 in 2009/10.⁴⁰⁹

⁴⁰⁸ The NHS Information Centre (2011) Mental Health Bulletin, Forth Report from mental health minimum datasheet (MHMDS), Annual Returns 2010. pp.10-13.

⁴⁰⁹ *Ibid.*, p. 20.

Viewed as part of the UK population as a whole, the numbers are small, nonetheless, for these service users, mental health disorders, unlike the majority of 'physical' illnesses, are often two-fold in their impact on the lives of those affected. Not only are the obvious psychological, emotional and cognitive functions disrupted by illness, the damage done to the individual is not just limited to the internal symptoms and the associated distress, it can also be difficult to assess the hidden impact that a diagnosis of 'mental illness' can have on any attempt at recovery and re-integration into the community.

The impact of social stigma is often far more traumatic than the root cause of the illness itself. A person diagnosed with a major mental illness inevitably has to cope with some degree of personal rejection, social avoidance and on occasion physical violence, all of which can be attributed as extensions of the negative cultural meanings associated with the mentally disordered. Negative responses to people who have admitted to being diagnosed as having had a mental illness are seen as major obstacles to recovery, severely limiting opportunities and more critically, undermining self-esteem.⁴¹⁰ It is this aspect of diagnosis and the effect of 'labelling'⁴¹¹ that have in part defined the MHA and its subsequent amendments as a negative concept of enforcement for the majority of mental health service users.

This as a recurring theme is important. The use of mental health legislation in practice can be distinguished from most other parts of the legal system in that in most circumstances, the various parties will have a vested interest in the legal process; the prosecutor acting on behalf of the state; the plaintiff pursuing a claim in Tort etc. By contrast, although many of the actors have clearly defined functions within the mental health system, they may, for various reasons be anxious to avoid their designated roles. Although mental health patients in their roles as consumers undoubtedly have an interest in accessing mental health services in order to get better, for the most part,

⁴¹⁰ Wahl, O. F. (1999) *Schizophrenia Bulletin*, 25(3): pp. 476-7.

⁴¹¹ For a wider discussion on the theoretical effects of labelling, the seminal work by Erving Goffman, is still the cornerstone of the debate. (1963) *Stigma, Notes on the management of Spoiled Identity*. NJ, Prentice-Hall.

service users do not see the MHA as an effective mechanism for providing - and more importantly - governing mental health services. For the majority of service users, first point of access to services is the local GP.⁴¹² However, unlike most physical ailments, a patient admitting to a GP that that he or she may be suffering from a mental illness, potentially engages the service user in a complicated legal journey, which for most people, is one of uncharted waters. Should the patient require more specialised services, such as out patient hospital treatment (even informally), they will as a matter of course fall within the remit of the MHA. At this point, depending on the nature and degree of mental disorder,⁴¹³ the issue of treatment is then one of qualified risk assessment. The patient's wishes may then be partially or completely overridden with the imposition of lawful restriction[s] under the compulsory powers of the Act.⁴¹⁴

The argument is in part substantiated by some service users experience of receiving mental health services. Many service users expressed a feeling of "disempowerment." where their views or wishes are not considered and they are allowed no part in the decision-making process about their care. In the Mental Health Foundation's report: *Something Inside So Strong—Strategies for Surviving Mental Distress*, one service user contributor provided the following description:

"I was also helpless, hopeless, I could not be trusted. I was dangerous if I did not religiously adhere to my appointments and medication regime. I would be an irresponsible patient by doing something to displease my multidisciplinary team. My psychiatrists were omniscient in relation to my situation. "⁴¹⁵

⁴¹² Airey, C., Boreham, R., Erens, B., and Tobin, R. (2003) National Survey of NHS patients, General Practice 2002, *Department of Health*, Online summary of key findings available: According to figures from the 2003 National Survey of NHS patients, approximately 91 per cent of people with a mental health problem will be treated within the primary care system. Accessed August 23rd 2009. http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/GPsurvey1999-2002/DH_4001356.

⁴¹³ MHA 2007, s.1 (2).

⁴¹⁴ MHA 2007, s. 2, 3, 4, 5(2) and 5(4).

⁴¹⁵ Dewan, V. (2001) (ed.), *Something Inside So Strong: Strategies for Surviving Mental Distress*, London, Mental Health Foundation, Extract from RB's success story, p. 33.

John O'Donoghue, in his biography expressed a similar sentiment when discussing his medication with his psychiatrist:

"Lets see if we can reduce the dosage, shall we?...Says Dr Popper...I think about the way doctors speak. Why do they always say 'We'?...I have no real choice in the matter, after all, I've been sectioned".⁴¹⁶

The possibility of medical treatment under compulsion raises a number of questions in law; can the State justify interference with individual rights, particularly following the incorporation of the Human Rights Act? Both the UK and the European courts have at various times ruled on consent to treatment (the capacitated patients wishes),⁴¹⁷ the therapeutic value of treatment,⁴¹⁸ the necessity for compulsion⁴¹⁹ and restrictions on the deprivation of liberty,⁴²⁰ Recent decisions by the courts have indicated that the principle of proportionality, which is regarded as the dominant theme underlying the Convention will remain central in clinical practice.

The Code of Practice (CoP 2008) now states within it's guiding principles that people taking action without a patient's consent must attempt to keep to a minimum the restrictions they impose on the patient's liberty, having regard to the purpose for which the restrictions are imposed.⁴²¹ Nevertheless, many service users continue to view psychiatric services with trepidation. Much of the underlying burden of mental illness will inevitably fall upon secondary parties such as family, often finding themselves in the role of carers.

As a consequence, the supportive nature of the relationship between the patient, family members and friends will often need to endure beyond the

⁴¹⁶ O'Donoghue, (2009), *Sectioned, a life interrupted*, London, John Murray Publishers. P.28.

⁴¹⁷ R (Wilkinson) v Broadmore Special Hospital Authority (2001) EWCA 1545, para 80, Hale LJ observed that "English law had not yet reached the point where it was an accepted norm that detained patients who fulfilled the criteria for capacity could only be treated against their will for the protection of others or for their own safety."

⁴¹⁸ Herczegfaly v Austria (1992), 15 EHRR 437. As a general rule, a measure, which is a therapeutic necessity, cannot be regarded as inhuman or degrading. The court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist.

⁴¹⁹ R (B) v Dr SS (2006) EWCA Civ 28, The proposed treatment was convincingly shown to be a medical necessity, was in the best interests of the patient and satisfied the requirements of s 58 of the 1983 Act.

⁴²⁰ SSJ v RB (2010), UKUT 454 (AAC). A Tribunal could not conditionally discharge with a condition which itself inevitably amounted to an Article 5 deprivation of liberty.

⁴²¹ The Code of Practice, Published pursuant to section 118 of the Act, 2008 London, TSO. Least restriction principle, 1.3, p. 5.

management of the immediate crisis, often involving them in a system of which they have little understanding.

Hence, for some of the actors that are directly involved, not only is there a reluctance to resort to the MHA as a procedure, the Act has little to commend it subjectively when compared to other parts of the legal system as a remedy of positive outcome. From the patient's standpoint, the potential for uncertain treatment and indeterminate detention coupled with the often intrusive imposition of treatment is further compounded by the often coercive character of voluntary or informal treatment whereby the majority of patients are admitted under section 131(1) of the MHA.⁴²²

Service-user confidence has been further eroded by the marked increase in the use of the Code of Practice to formalise many informal admissions.⁴²³ Changes from informal to all four parts of the Part II sections have also increased dramatically over the last decade. The largest rises having been in changes from informal to Section 2 and informal to Section 3,⁴²⁴ though in addition there were a significant number of patients whose status changed from Section 2 to Section 3 of the Act.⁴²⁵

4.2 The doctor patient relationship.

The relationship between the patient and the medical professional in psychiatric health care operates in a significantly different manner to the conventional participatory model that is seen in doctor patient relationships in relation to mainstream physical illness. Once a patient is involved with psychiatric services, there is a legitimate concern that the process leading to discharge is fraught with personal difficulties. Unlike physical illness, it may be

⁴²² Informal admission of patients.

⁴²³ Total formal admissions rose to 28,700 in 2008-09 from 28,100 in 2007-08. Total detentions, including detentions subsequent to admission and detentions after removal to a place of safety, rose by 100 to 47,700. The NHS Information Center for Health and Social care, (2009) Table 2a, p25, though it should be noted that many formal admissions would have been for relatively short periods, i.e. 72 hours *as per* s.5(2) & s.5(4).

⁴²⁴ Statistical Bulletin 23 (2007) The Information Centre, Mental Health Statistics. Table 4, p. 7, ISBN: 1-84636-110-9, London, HMSO.

⁴²⁵ *Ibid.*, p.7.

necessary for the mentally distressed patient to establish his own competence in circumstances where his/her wishes are compromised subject to more overriding concerns.

Though this thesis does propose to review the framework and delivery of health care in England and Wales, with relevance to the first point discussed above, it is nonetheless appropriate at this point to dwell upon the differences that are critical in the delivery of mental health services from those of “mainstream medicine”.

The application of the traditional primary, secondary and tertiary model of care to mental health does in practice differ considerably from the conventional treatment of physical illness. Primary care teams - the GP, practice nurse, community district nurse and others - generally manage continuing or long term care of chronic physical illness. In contrast, the continuing care of seriously ill mental health patients is considerably more fragmented, as the locus of care is from the discharging hospital rather than the PCT.⁴²⁶

One effect of this differential is that for mental health patients living in the community, there is often a lack of defined responsibility in co-ordinating care. The contemporary model is, as discussed previously, often referred to as participatory. The patient (consumer) engages with the system at the point of entry (Local GP/ Primary Care Trust etc), with the Doctor (resource manager) deciding treatment on a needs basis, and the state (as principle) providing funding. Arguably, the use of “participatory” as a feasible description is at best questionable. For the most part, although there is a presumption that the patient has the right to be informed of his treatment and refuse such treatment

⁴²⁶ Primary care Trust (via localised trusts under the umbrella of the Strategic Health Authority) essentially equates with general practice care; secondary care is specialised care, usually hospital managed who receive patient referrals from secondary level specialists (the Consultants). However, in mental health care, primary care deals with the vast majority of morbidity; secondary care is predominated by general mental health care teams dealing with more serious neurotic and psychotic illness. Tertiary care is generally the more specialist including forensic psychiatric services that are usually hospital based, in medium or high security units, or which can operate community teams in conjunction with secondary, primary and other services. Practice Based Commissioning, DOH, 00000 Op, Oct 04 Crown Copyright.

if he so wishes, in practice, the real character of the doctor patient relationship is very much one of neo-classical paternalism rather than equality and concurrence. Even from a conservative perspective, commentators such as Jacob⁴²⁷ question the relevance of any notion of a participatory model when viewed in practice as a consensual arrangement.

In reality, the health care professional is in a position of much greater authority built on expertise supported by institutional determinism, whilst the patient's situation is one of disadvantage driven by subjective need.

Though as an observation, this may appear overly simplistic, it is nonetheless valid in context; in "mainstream" health care, there are certain presuppositions regarding informed consent,⁴²⁸ however, on the basis of the above, it is difficult to accept that there is in fact an equality of interest in the doctor-patient relationship. As Jacob suggests:

"The engaged practitioner does not have either the patient's pain nor can he or she share the same hope of a cure, the one wants restoration and the other if no more a job done well. In a nutshell, medicine deals with patients, sick people. It does not deal with citizens."⁴²⁹

Furthermore, he argues that although "consent may be free it cannot be full. The asymmetry of the relationship prevents it".⁴³⁰ As a consequence, in practice, where the physician gives advice (orders) as to treatment, it is implicitly recognised that patient's moral agency (choice) is temporarily compromised and thus effectively subordinate to the clinician's professional opinion. However, when comparing physical ill health to mental dysfunction, the doctor-patient relationship takes on a different perspective; it is the doctors' wider appraisal of "need" rather than the patient's willingness to be treated that is critical and more importantly, a position that could suspend the

⁴²⁷ Jacob, J. (1998) *Doctors and Rules: A Sociology of Professional Values*, 2nd Edition, New Brunswick NJ, Transaction Publishers, p. 25.

⁴²⁸ The potential for a battery or tortious action in negligence is clearly implied by the test in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582; where the patients best interests are protected in accordance with a responsible body of medical opinion.

⁴²⁹ *Op. cit.* p.206.

⁴³⁰ *Op. cit.* p.208.

patient's agency indefinitely. In practice the resort to coercive compliance is always on the agenda; medical notes routinely state "section if tries to leave" or "will need to be sectioned if refuses medication".⁴³¹ Thus, the presence of compulsion is firmly embedded in the psychiatric system.

Contextually, how does this affect either the patient's willingness to be treated or the doctor's motivation in offering care outside the statutory framework? Arguably, recourse to the MHA has a negative impact in that, when it is necessary to provide treatment as prescribed by the Act, it only does so at a relatively late stage in the development of illness when intervention is required. This would seem to be contrary to other areas of medicine where proactive preventative care is the expected norm.⁴³² Moreover, patients who present themselves at the G.P.'s at an early stage of mental ill health are often not taken seriously as they fail to fit the stereotype that typifies the General Practitioners experience of a mentally ill patient in need of crisis intervention.⁴³³

By contrast, the physically ill counterpart may, even against the physicians' advice, choose not to consent,⁴³⁴ or to withdraw consent from treatment altogether. For the mentally ill patient, once in contact with the mental health services, the doctor-patient relationship, when overshadowed by the MHA is frequently one of endurance and survival. In such circumstances, the loss of personal agency/autonomy is all too apparent, not because of the nature of the patient's illness at the onset of treatment but on the basis of the apparent potential to realise the necessary criterion to engage the MHA. This position can often be a source of further instability, as the patient's concerns and suspicions as to assessment and subsequent treatment are routinely seen as symptomatic manifestations of illness themselves, thereby adding some

⁴³¹ The author has had many years experience as a Support Worker and Health Care Assistant in the social care sector. One client who had a fear of needles, when faced with giving a blood test, would be told, "well if you don't let the community nurse do it you'll have to go to 'The Unit' and you know what that means."

⁴³² For example, the help available to help smokers quit, SCMH, (2006), Policy Paper, The Future of Mental Health: a Vision for 2015.

⁴³³ This point will be the subject of further discussion later in this Chapter.

⁴³⁴ Though this may be subject to interpretation by the courts following cases such as *Re C (Adult: Refusal of Treatment)* [1994] 1 WLR 290 Fam Div & *Re MB (Medical Treatment)* [1997] 2 FLR 426.

weight to the validity of the clinician's decision. As a consequence, insofar as mental illness is considered, the more serious the circumstances surrounding the patient's condition, the more likelihood there are for grounds for detention. Whereas the patient who is suffering from a physical illness is as a matter of course likely to benefit from a definitive prognosis; pre-op, procedure, post-op and discharge, with a measure of assurance as to the outcome (benefit), the mentally ill patient is often in the position where a course of treatment may be started without any guaranteed benefit in either the short or long term. From the service users' point of view, once the system is engaged, the law allows the patient little autonomy in the clinical process. Though there are formal safeguards that endeavour to protect against loss of agency, the overriding function of the legislation is its capacity for public protection, subsequently the doctor-patient relationship may be pursuing differing objectives for very different reasons.

Arguably, loss of agency in such circumstances should not be considered solely in terms of lawful restriction in order to protect against risks to the community or individual. For many patients, the costs and benefits of treatment, consensual or otherwise, may substantially affect the patient's quality of life beyond the formal safeguards/restrictions provided by legislation.

For example, many anti-psychotic drugs produce side effects that many individuals find intolerable. Stelazine⁴³⁵ can cause lockjaw and joint stiffness, tremor (uncontrolled shaking), drooling, trouble swallowing, and problems with balance or walking. As a consequence patients are regularly proscribed Kemadrine⁴³⁶ to counteract the side effects of Stelazine, however Kemadrine if taken for extended periods, can cause Xerostomia (dry mouth syndrome) and spatial disorientation.

The use of ECT (Electro Convulsive Therapy), although not as common as in the past, is still regularly used, despite serious misgivings concerning its

⁴³⁵ Generic Trifluoperazine, Goldshield Pharmaceuticals .
http://www.medicines.org.uk/emc/medicine/22564/SPC/Stelazine%201mg%20Tablets#UNDESIRABLE_EFFECTS

⁴³⁶ Generic Procyclidine Hydrochloride, Wellcome (France).

use.⁴³⁷ Understandably, the high incidence of side effects leads many patients to abandon their medication,⁴³⁸ with the consequence of relapse and the whole cycle begins again, leading to what has come to be known as the 'revolving door syndrome.'

For the patient, it is not only individual personal autonomy that is liable to encroachment, but in practical terms, day to day function at both physical and social levels is also likely to be diminished by procedures that are broadly sanctioned in law, yet ill defined in practice and with few real opportunities to object.

As one mental health user explained, loss of control is a way of life for anyone diagnosed with a mental disorder:

"...no psychiatric professional has ever advised me on how to cope with a breakdown beyond the blanket exhortation to keep on taking the drugs. My own experiences suggest that once I lose control again I am expected to admit powerlessness, hand myself over to the experts and start counting".⁴³⁹

More recently, Channel 4's dramatic adaptation of *Poppy Shakespeare* has done much to highlight the futility of a system where there is a real fear in many service users minds that "being forgotten" is an ever-present reality.

"There seems to be some sort of agreement, a contract you sign when you first break down (you won't remember, you were out of it) that should you ever emerge from your madness and re-enter the "normal" world, you promise never to mention what took place. If you break this agreement, at best you'll find people's eyes start to drift away, drinks suddenly need

⁴³⁷ Controversy surrounds the safety, ethics and necessity of ECT. In particular, some mental health service users believe that the side-effects can be quite severe and that they have had ECT administered to them either against their will, or without their knowledge (in cases where people are so depressed that they are unaware of what is going on around them). Specific complaints include: poor standards, limited benefits, memory loss, psychological adverse affects and the risk of serious physical injury or death. www.mhf.org.uk/information/mental-health-a-z/electroconvulsive-therapy/ 08/03/08.

⁴³⁸ A mental patient died after drugs were administered to against the wishes of his family, an inquest heard. Coroner David Hinchliff, who recorded a long narrative verdict, heard that Rohan – who suffered from delusions and was occasionally violent – had collapsed once before in Lincoln County Hospital when he was being treated with Clozapine. Yorkshire Eve Post 13 April 2007.

⁴³⁹ Campbell, P. (1989) "Peter Campbell's Story" in Brackx, A. & Grimshaw, C. (eds.) *Mental Health Care in Crisis*. London, Pluto Press. P. 11.

replenishing, embarrassment hangs in the air; at worst, you'll be shunned. At the very worst you will discover you've become an object for general pathology.”⁴⁴⁰

Understandably, from a patient's perspective, the actuality of an illness-specific body of law becomes largely superfluous in a framework that largely is based on latent coercion. Consequently, there is a grey area where patients, both formal and informal are subject to a potential for loss of agency by activity that in practice moves the doctor/patient relationship outside of the proscribed framework of the law. This can be further argued in that where physical medicine is for the most part about healing illness/disease with the relationship terminated once a cure is effected, psychiatry employs the use of compulsion as a clinical device to be used as and when the psychiatrist sees fit, with patients complying with treatment in order to avoid compulsion. This is a situation, which in practice can cause resentment and in the long term becomes anti-therapeutic.⁴⁴¹

To use an old adage, when applied to mental health, there is a substantial difference between “law in books and law in action.” In short, the conservative approach by legislators has burdened the service user with a system that though procedurally strong on paper, is substantially weak in practice. Latent coercion within the framework of the MHA remains a fundamental hurdle for many service users in accessing appropriate support and health care.

4.3 Hospital admission and discharge

For many patients, the final crisis in their journey comes with in-patient admission to hospital. The following discussion considers some of the criticisms made by service users and more significantly other interested stakeholders. Out of necessity, the majority of the comment comes from Commissioners reports and other sources rather than service users directly because of the difficulties in obtaining contemporaneous comment.

⁴⁴⁰ Claire Allen, *'It's My Life,'* The Guardian, 27th September 2006.

⁴⁴¹ Lidz, C. et al, (1995), “Perceived Coercion in Mental Hospital Admission: Pressures and Process” *Archives of General Psychiatry*, 52, pp.1034-9.

A week before he began his term of office, Professor Dinesh Bhugra the incoming president of the Royal College of Psychiatrists admitted that Acute psychiatric wards in England and Wales are now so poor, that he would not use them himself - nor allow a member of his family to do so.

'You don't go to hospital to get hurt, but that's what's happening in our acute psychiatric wards...some are uninhabitable. It's completely and absolutely unacceptable.'⁴⁴²

This, no doubt, reflects on the recent release of Mental Health Act Commissions' twelfth Biennial Report: *Risks, Rights, Recovery*.⁴⁴³ Though there were many positive aspects in the report, from both service users and professionals perspective, the report only served to reinforce fears that despite a considerable investment of an extra £1 billion of government funding, little has changed in the intervening decade. In 1995, Tony Zigmund⁴⁴⁴ stated:

"...that how conditions in special care wards can depart so markedly from an acceptable standard, brutalising the staff and making it harder to maintain standards of humane care, is telling."⁴⁴⁵

More recently, the Mental Health Act Commissioners found that practitioners were being told to delay sectioning people with urgent mental health needs until primary care trusts determine who should pay for their treatment. The problem was blamed on high bed occupancy levels and the need for Primary Care Trusts to balance budgets.⁴⁴⁶ Though this was seen as a major failing on the part of service providers, it only serves to highlight that resources (or the lack of) remain central in managing residential units.

Other issues ranged from sub-standard accommodation - one Commissioner likened the state of a ward he visited "as a building site" - to excessive

⁴⁴² Hill, A. 'The mental health units that shame the NHS', The Observer, Sunday June 29 2008.

⁴⁴³ Mental Health Acts Commission, *Rights, Risks and Recovery: Twelfth Biennial Report*, 2005-2007 (2008).

⁴⁴⁴ Former President of the Royal College of Psychiatrists and Mental Health Commissioner.

⁴⁴⁵ Zigmund, T. (1995) "Special Care Wards; Are They Special?" *Psychiatric Bulletin*, pp. 310-12.

⁴⁴⁶ Mental Health Acts Commission, *Rights, Risks and Recovery: Twelfth Biennial Report*, 2005-2007 (2008) Taken from the abstract.

occupation rates; acute wards with 135% bed occupancy – patients sleeping in day rooms – no curtains – mattresses stowed away by day – no space for belongings – staff run off their feet with not time to talk to patients.⁴⁴⁷

An unsustainable workload on an acute unit: i.e. 100% occupancy, with high numbers on s.17 leave - informal patients admitted to a psychiatric intensive care unit (PICU) as no other beds available - nurses working flat out.⁴⁴⁸

The report also mentioned many other equally disturbing facts:

- Vulnerable women housed with predatory men – alleging physical / sexual abuse – unwilling to take complaint forward due to fear of what would happen and lack of control over the process. Had told male member of staff who had laughed it off.⁴⁴⁹
- A male patient who is secluded 90% of the time– no quality of life – no other service willing to take him.⁴⁵⁰
- One detained patient described how he was very worried about his life and future as he had raped another detained patient and nobody had discussed these issues with him. When it was brought it up with the managers, they said that it had been ‘dealt with’.⁴⁵¹
- A patient discharged into the community without a care plan, support from social services or a place to stay. The patient subsequently left the ward, and was found dead at bottom of a viaduct a week later.⁴⁵²

⁴⁴⁷ Mental Health Acts Commission, *Rights, Risks and Recovery: Twelfth Biennial Report, 2005-2007* (2008), p. 16.

⁴⁴⁸ *Ibid.*, pp. 16-18

⁴⁴⁹ *Ibid.*, pp. 16-18

⁴⁵⁰ *Ibid.*, pp. 16-18

⁴⁵¹ *Ibid.*, pp. 16-18

⁴⁵² *Ibid.*, pp. 16-18.

- A forensic patient who had been in a PICU for three years, returned to prison four months before the end of his sentence, where no after care plan would be available.⁴⁵³
- A teenage patient with learning difficulties having his arm broken in two places as a result of 'restraint'.⁴⁵⁴
- A detained patient who clearly lacked capacity being treated with a Form 38.⁴⁵⁵ This patient was also being treated for physical problems that were probably side effects of his psychiatric treatment.⁴⁵⁶

As it would be unacceptable for such conditions to exist on wards for the physically ill, it is even more disturbing that such conditions as described in the 2008 report refer to an inspection period over six months prior to November 2007. Though the above are only a selection of the report's findings, they are consistent with comments made by the MHAC in previous years.

The Thirteenth and final report,⁴⁵⁷ though for the most part acknowledging that good practice was improving, somewhat disturbingly noted that while the number of deaths of detained patients on psychiatric wards by hanging was gradually showing a downward trend, 10% of deaths between 2000 and 2008 occurred in patients who were either under continuous or intermittent (up to 15 minutes) observation. Though a very small number relative to the detained population at any given time (between 2000-2008, 130 patients died), the report was extremely critical that such tragedies could still occur.⁴⁵⁸

⁴⁵³ *Ibid.*, pp. 16-18

⁴⁵⁴ *Ibid.*, pp.16-18.

⁴⁵⁵ Written certification of the patients understanding and consent to treatment as per s58 (3) subject to s62 MHA.

⁴⁵⁶ *Ibid.*, pp. 16-18.

⁴⁵⁷ Mental Health Act Commission, *Coercion and Consent* Thirteenth Biennial Report, 2007-2009, London,: The Stationary Office.

⁴⁵⁸ *Op. cit.* 5,53 p. 221.

n.b. The Corporate Manslaughter and Corporate 5.11 Homicide Act 2007 came into force in April 2008. Thus, NHS or independent bodies can be found guilty of an offence if the ways in which their activities are managed or organised by its senior management cause patient's death or amounts to a gross breach of a relevant duty of care. Section 2(1)(d) of the Corporate Manslaughter Act.

The Thirteenth report was also critical of the failure to implement the findings of earlier reports, particularly staff numbers, with many staff complaining that the levels of staffing sometimes made the wards unsafe.⁴⁵⁹ There was lack of information supplied to detained patients as to their rights and legal status;⁴⁶⁰ staff training in 'safe' restraint techniques and that earlier recommendations regarding the use of seclusion had not been implemented. In one instance: the use of restraint in full view of other patients on the ward occurred because there wasn't a seclusion room available.⁴⁶¹

That the various reports' findings imply that such conditions still occur on psychiatric wards in the UK today, rather than a third world country, is indicative of wider concerns expressed by many of the stakeholders, despite the fact that various Health Ministers have stated that mental health is a priority service. On the whole, the Commissioners findings show only a marginal improvement over previous years with little progress towards a more unified hospital service.

Although resources are inevitably quantified in finite terms, it is self evident that lack of resources inevitably affects the clinical relationship. This is manifest in a number of ways: Inadequate numbers of in-patient beds, overcrowded or mixed sex wards;⁴⁶² and staff shortages. These inevitably mean that some service users receive treatment as a worse case scenario; as a consequence many patients who would have benefited from informal treatment as a day patient or in the community are admitted at a much later stage of crisis in their illness, with the likelihood that such admissions are the result of legal coercion.

⁴⁵⁹ Thirteenth Biennial Report (2008), 1.78 p.50.

⁴⁶⁰ Under s.132 of the Act, detaining authorities have a statutory duty to provide detained patients information about their legal position and rights.

⁴⁶¹ *Ibid.*, 1.154 p.78.

⁴⁶² The Healthcare Commission found that in 2009 that two-thirds of psychiatric inpatients in England and Wales were still sharing sleeping accommodation or bathrooms with the opposite sex. <http://www.psychminded.co.uk/news/news2009/jan09/mixed-sex-wards006.htm>. Accessed 20th March 2010.

Thus for many service users, the failure of resources to meet their needs is deficient in the short-term and does little to encourage or sustain the patient doctor relationship in the long-term. For example, the absence of an available SOAD or APMH in making changes to medication or drawing up a care plan can cause unnecessary delays in discharging a patient. Such circumstances inevitably create difficulties in preparing patients for release, creating unnecessary uncertainty for many service users as and when they may be allowed to return to the community. Recent comments in the Guardian by Tony Zigmond, from the Royal College of Psychiatrists, expressed concern over the lack of infrastructure in applying the amendments of the 2007 Act, stating that:

"He is concerned that the shortages mean that patients aren't getting proper legal protection and that any changes in medication are taking longer than they should due to delays in obtaining approval of doctors who can give a second opinion...."Within 28 days of a CTO release, you must have a second opinion," he says. "If you don't, the treatment must cease unless it's an emergency... The delays remove a necessary safeguard, which is a legal requirement and clinically important, and may delay or prevent a patient receiving the treatment they need at the time they need it,"... he says... "In the meantime, patients are suffering, and their period of detention in hospital is likely to be increased."⁴⁶³

This raises the possibility that many service users still end up being discharged with inadequate access to relevant support, relapse and being readmitted under duress in a cycle that is euphemistically known as '*revolving door syndrome*,' the problem that CTO's were intended to address, with the inevitable result that hospital stays become extended with each further admission. For many people, the continuing absence of certainty relating to their illness and the knowledge that they may be liable to be recalled and sectioned substantially undermines the therapeutic value of the treatment that they receive. Recent studies have indicated that Crisis Resolution Home Treatment (CRHT) teams provide intensive support to people during a mental health crisis in community settings, as an alternative to hospital admission.⁴⁶⁴

⁴⁶³ Extracted from an article in the Guardian by Mark Gould, '*Hazards of a health safeguard*' The Guardian, Wednesday 13 May 2009.

⁴⁶⁴ National Audit Office, (2007) *Helping people through mental health crisis: The role of crisis resolution and home treatment services*. London, HMSO.

A key role of these teams is to act as a conduit to people requiring access to mental health services or other emergency care and to identify whether an alternative to admission is appropriate. Early care intervention through crisis management, coupled with an ongoing home care support package, is viably economic and an acceptable way of treating people with serious mental illnesses as opposed to hospitalisation.⁴⁶⁵

4.4 Social exclusion, “them and us”.

The difficulties of living with mental illness are a recurrent theme; most service users describe how it is impossible to ignore their symptoms. The impact of the illness itself and its diagnosis, the effect on family and friends, the workplace, accessing NHS services and personal finances are all indicative of the problems that many service users have in maintaining their identity and self-esteem. The experience of mental illness was almost impossible to describe with any degree of rationality to those who had never experienced mental distress:

“A person in good health simply doesn’t experience the things, the emotions, and the feelings that we as people suffering from mental distress go through. And trying to get across to somebody who hasn’t ever felt like, you know, the sword of Damocles hanging around your neck for apparently no good reason, you know, you can’t do it. It’s like trying to explain colours to a blind person (Paul, Coventry)”⁴⁶⁶

There are two facets to the life of an individual suffering from mental distress, their interaction with the mental health services in trying to treat the illness and the social environment in which they find themselves. The first is a journey through the bureaucracy of engaging with the health care services, the second is a situation involving multiple factors such as employment, finances, personal family circumstances and stigma, all of which generate and amplify

⁴⁶⁵ Joy, C. Adams, C. & Rice, K. ‘Crisis intervention for people with severe mental illnesses’. Cochrane Database Syst Rev. 2006 Oct 18; (4): CD001087. Review. PMID: 17054133; Cochrane Schizophrenia Group, 15 Hyde Terrace, Leeds University, Leeds, UK. www.ncbi.nlm.nih.gov/pubmed/17054133?dop. Accessed 21st March 2010.

⁴⁶⁶ Lester, H. & Tritter, J. ‘Listen to my madness: understanding the experiences of people with serious mental illness. *Sociology of Health and Illness* Vol. 27 No. 5, 2005 p. 657.

experiences and episodes. Both are dynamic and interconnected. For many service users, it is the first part of this equation that is most problematic.

The lack of self-esteem and anxiety suffered by many service users with affective disorders such as depression often makes accessing primary health care difficult. For many service-users, standing at a doctor's reception desk and explaining to the receptionist what is wrong with them in close proximity to other patients only adds to the sense of stigma. Negative attitudes to mental distress are as common among people who have experience of mental distress as among those who have not. Where a person with mental distress holds negative attitudes to his own condition, this can be seen as a form of 'internalised stigma'. Research into other health conditions (such as HIV) and specific social groups (such as the gay community) has shown that internalised stigma can have detrimental effects on the way people see themselves, including low self-esteem and feelings of self-loathing.⁴⁶⁷

Andy Bell of the SCMH argues:

"Like sexuality, mental illness is something people are often reluctant to identify themselves with in the workplace. It arouses mixed emotions and is hard to empathise with."⁴⁶⁸

Similar psychological effects are produced when people with mental distress experience internalised stigma. Many service users have reported negative attitudes from mental health professionals. Research suggests that psychiatrists' attitudes to specific mental health conditions can influence the diagnosis a person receives.⁴⁶⁹ This is particularly significant in patients with vague, contested or dual diagnosis, as Angela Kelly stated in a letter to the e-British Medical Journal:

"The categorization of an illness as being psychosomatic also means a further categorisation of an individual as 'deviant' rather than 'ill', so that they are denied sympathy, support, and

⁴⁶⁷ Thornicroft, G. 2006, 'Tackling discrimination', *Mental Health Today*, June, pp.26-29.

⁴⁶⁸ Bell, A. "Us and Them" *BMJ*. 2003 February 1; 326(7383): 291.

⁴⁶⁹ Kingdom, D. et al 2004, 'What attitudes do psychiatrists hold towards people with mental illness', *Psychiatric Bulletin*, 28, pp.401-406.

even benefits they are entitled to. Categorised as 'deviant', the ill then suffer increasing social exclusion and material inequalities."⁴⁷⁰

There is also evidence that suggests that patients with any previous history of violence rather than a violent clinical history are more likely to be diagnosed with schizophrenia type symptoms than affective disorders.⁴⁷¹ Psychiatric diagnosis, being 'syndrome based' and lacking objective investigations that either confirm or exclude diagnoses, is as a consequence particularly vulnerable to prejudice and bias. Under such circumstances, wrongful diagnosis may lead to a patient receiving less effective treatment and education about their illness and a greater likelihood of receiving a restriction order.⁴⁷² At a practical level, such uncertainties often lead to patients being severely disadvantaged in both clinical and social recovery; in many cases the lack of positive diagnosis diminishes the process of the re-establishing a satisfactory sense of personal identity.⁴⁷³

Fear of being subject to such negative predispositions has suggested that patients are often overly cautious when presenting symptoms at GP's surgeries. The need to appear lucid whilst in a state of crisis was for many patients both difficult and upsetting. On the other hand, many service users voiced the opinion that if they appeared too *'together'* the receptionist might not believe that they needed an urgent appointment.⁴⁷⁴

A recent Poll by The Scottish Executive in support of the "See Me" Campaign found that around 83% of respondents were reluctant to disclose information about their condition, even to medical professionals; Linda Dunion, the Campaigns Director stated that:

⁴⁷⁰ The Mental Health Movement: Persecution of patients. Background briefing for the House of Commons Select Health Committee, document prepared for the Countess of Mar by Malcolm Hooper, Emeritus Professor of Medicinal Chemistry, Department of Life Sciences, University of Sunderland, Dec 2003.

⁴⁷¹ Clark, T. & Rowe, R. 2006, 'Violence, stigma and psychiatric diagnosis' *Psychiatric Bulletin*, Vol. 30, pp. 254-256.

⁴⁷² Section 41 of the Mental Health Act.

⁴⁷³ Whitwell, D, (2005) *Recovery Beyond Psychiatry*. London: Free Association Books.

⁴⁷⁴ Lester, H. & Tritter, J. 'Listen to my madness: understanding the experiences of people with serious mental illness. *Sociology of Health and Illness* Vol. 27 No. 5, 2005 p. 658.

“Not being able to predict how others will react presents real difficulties in everyday situations, from the family and friends to the workplace and the community.”⁴⁷⁵

Unfortunately such fears are often well founded, and are reinforced every time someone overhears others treating mental ill health as a joke or as something to be scared of. For example, the lack of privacy in most GP’s surgeries and the close proximity of other patients in the waiting room often produce situations that are real obstacles for service users in managing their illness. Such interactions are a recurrent issue for many service users, but are in general not recognised as important by many health care professionals, leading to many GP’s labelling service users as irrational, unreliable and malingering, unaware, that the behaviours they were describing as negative were often representative of service users attempts to navigate the health care system. Understandably, patients’ efforts to cope with such negative perceptions often result in individuals re-evaluating their own position, for example, by keeping their illness secret or withdrawing from potentially stigmatising social situations.⁴⁷⁶ However, the adoption of negative coping strategies can be harmful as they often result in social isolation and reinforce the stigmatising self-image within the patients perceived self-identity.⁴⁷⁷

As previously discussed, most service users were familiar to some extent with the complex interactions between the manifest symptoms of their illness and the way in which health providers perceive them. Some service users described a process of dramatising their impairment in order to be taken seriously in negotiating the gate-keeping function of primary care. This behaviour most frequently occurred when trying to access additional care or sick certificates, though it was acknowledged that such over-acting tended to reinforce the widely held stereotype of ‘over the top’ behaviour and

⁴⁷⁵ Anon, 2006, ‘Poll shows mental health stigma’ *BBC News Online* Nov 6 2006. <http://news.bbc.co.uk/1/hi/scotland/6118944.stm>, accessed 02/08/08.

⁴⁷⁶ Baumann, A.E. (2007), *International Review of Psychiatry*, Stigmatisation, social distance and exclusion because of mental illness: The individual with mental illness as a ‘stranger’. Vol. 19, No. 2 , pp. 131-135.

⁴⁷⁷ Link, G. Streuning, L. Rahov, M. Phelan, J. & Nuttbrock, L. (1997) ‘On Stigma and its Consequences; Evidence from a Longitudinal Study of Men with Dual Diagnosis and Substance Abuse.’ *Journal of Health and Social Behaviour* 38: pp. 177-90.

malingering.⁴⁷⁸ Nevertheless, it is significant that whereas the spotlight remains much on risk assessment, many service users have had difficulty in accessing services during the build-up to a mental health crisis. This however, should be appreciated in context, as the time between the onset of illness and the point at which the individual sufferer actively seeks help is by nature subjective. Nonetheless, studies have indicated that the majority of service users feel that they are only taken seriously when a crisis occurs, rather than benefiting from early treatment and intervention.

Nevertheless, it would seem that in general the majority of service users for various reasons experience difficulties in accessing primary care; as one member of a focus group stated:

“When I’ve had difficulties getting an appointment, especially after I’ve been really unwell, I’ve asked my vicar to come with me to the surgery because they’ll listen to him. You need someone with power and authority. Authority is important. You need someone to be able to act (Rachel Worcester).”⁴⁷⁹

What has emerged is the importance that the voluntary sector plays in many service users lives. In a recent survey of volunteering by people with mental illness carried out by the National Center for Volunteering⁴⁸⁰, the survey found that nine out of ten people said volunteering gave them a sense of purpose and achievement and eight out of ten said it had a positive effect on their mental health. Four out of ten people also felt it had increased their chances of employment. However, whereas many service users consider employment or uncertainty about future employment as a very important part of their recovery, most service users as patients felt that health care professionals largely ignored these concerns.

⁴⁷⁸ Lester, H. & Tritter, J. ‘Listen to my madness: understanding the experiences of people with serious mental illness. *Sociology of Health and Illness* Vol. 27 No. 5, 2005 p. 662.

⁴⁷⁹ Lester, H. & Tritter, J. ‘Listen to my madness: understanding the experiences of people with serious mental illness. *Sociology of Health and Illness* Vol. 27 No. 5, 2005 p. 663.

⁴⁸⁰ Institute for Volunteering Research 2003: *Volunteering for Mental Health*. London, University of East London.

4.5 Mental illness as a disability

The number of people claiming Incapacity Benefit (IB) because of mental health problems has doubled from 475,000 in 1995 to 1,005,890⁴⁸¹ in 2008; with a further 58,200 people claiming Severe Disablement Allowance (SDA).⁴⁸² This does not include those with secondary mental health problems or who develop mental health problems while on IB. More people claim IB and SDA for mental health reasons than the total number of Jobseekers' Allowance claimants. People with long-term mental health problems have the lowest employment rate of any of the main groups of disabled people.⁴⁸³ Historically, disability as a generic label has in general been reserved for those with obvious physical limitations. However, following the Disability Discrimination Act (DDA) 1995, the definition of 'disabled' included people with a mental impairment that has a substantial and long-term adverse effect on their ability to carry out day-to-day activities.⁴⁸⁴ At a practical level, the DDA within the context of employment and provision of services, the introduction of Direct Payments Legislation 1996 and the establishment of the Disabilities Rights Commission (DRC) 2000, has had a considerable effect in allowing individuals more autonomy in living with their illness, but there remain a number of issues within the application of certain aspects of legislation that are still seen as problematical by service users. Foremost is the qualifying requirement that 'impairment' must be consequential from or consisting of a mental illness only if the illness is a clinically well-recognised illness.⁴⁸⁵

Although there has been some direction by the judiciary as to what amounts to a clinically well-recognised condition,⁴⁸⁶ it is arguable that for many service users with mental health issues, the uncertainty of the imposition of an

⁴⁸¹ Department of Work and Pensions, <http://www.dwp.gov.uk/asd/statistics.asp> accessed 03/07/08.

⁴⁸² Since April 2001, no new claims for Severe Disablement Allowance have been allowed. However, people who were receiving SDA before this date can continue to receive it provided that they remain eligible.

⁴⁸³ Office for National Statistics, *Labour Force Survey (LFS)*, August 2003, figures for England only. The definition of 'disabled' is in line with the definition used within the Disability Discrimination Act 1996 which includes people with a mental impairment that has a substantial and long-term adverse effect on their ability to carry out day-to-day activities.

⁴⁸⁴ DDA 1995 Sch. 1, para 1(1).

⁴⁸⁵ DDA 1995 Sch. 1, para 1(1). 2, 4 & 5.

⁴⁸⁶ EAT in *Morgan v Staffordshire University*, [2002] IRLR 190.

additional statutory barrier that applies to applicants with physical impairments is something of an incongruity. The ambiguity between what is meant by mental impairment and recognised mental illness has in part been addressed by the DDA 2005⁴⁸⁷, which diluted the inconsistency on the basis that there was no such requirement that a physical impairment must be similarly classified.

However, although it now appears that the statutory use of 'impairment' does not *per se* call for any specific clinical definition, substantive reference to case law⁴⁸⁸ suggests that a degree of clinical diagnosis is unavoidable when referring to mental ill health. Nonetheless, there are many people who are unable to meet the criteria for statutory disability, despite suffering from long term and debilitating impaired mental health. Arguably there is a need for a fundamental evaluation of the practical relationship between mental ill health, impairment and social exclusion, with more emphasis on addressing society's response rather than placing the onus on people with a history of mental health problems.⁴⁸⁹ Despite recent progress, many of the exclusory issues that legislators have addressed, have in fact created a minefield of minimalist negative outcome rather than any positive direct effect. Oliver argued as far back as 1983 that:

'...nothing more fundamental than a switch away from focusing on the physical limitations of particular individuals to the way in which the physical and social environments impose limitations on certain groups or categories of people.'⁴⁹⁰

A position, which has changed little in the intervening years. The implementation of the Equal Treatment Directive 2000/78/EC⁴⁹¹ contributes little to the existing domestic position, as the Directive is only a framework of national implementation measures that allows member states a considerable degree of latitude in its implementation, rather than a regulation. Arguably,

⁴⁸⁷ DDA 2005 Chapter 13, section 18, *The Meaning of Disability*, The Stationary Office.

⁴⁸⁸ *Goodwin v Patent Office* [1999] ICR 302. See also C.A. decision in *McNicol v Balfour Beatty Rail Maintenance*, [2002] IRLR 711.

⁴⁸⁹ Mind website, accessed at: <http://www.mind.org.uk/About+Mind/> accessed 07/07/08.

⁴⁹⁰ Oliver, M. (1983), *Social Work with Disabled People*, Basingstoke McMillan, p.23.

⁴⁹¹ The DDA 1995 (Amendment) Regulation 2003, SI 2003/1673.

despite its apparent shortcomings, much of the UK's existing domestic legislation was and remains more comprehensive than the majority of other member states.⁴⁹²

As many critics have argued,⁴⁹³ for there to be any significant improvement in advancing the rights of mental health users, a paradigm shift in the fundamental way in which we view service users needs is required. The lack of consistency between areas of law such as the MHA and DDA, questions the value of any substantive attempt at dialogue within such limited constraints.

4.6 A broader approach to social construction

The following discussion considers how adopting socio-political perspectives in understanding the various issues; can in practice influence and benefit mental health services, and importantly, the people who rely upon them.

While there has been considerable empirical research into service user demographics,⁴⁹⁴ with much of the data being quantitative using CAPI technology⁴⁹⁵ with data reflecting gender, ethnicity and marginalisation relative to admissions and public opinion etc⁴⁹⁶, it has for the most part been seen as an objective resource for policymakers in predicting admissions, benefit claims, provision of services and education rather than addressing individual needs. By contrast, the majority of service user driven research is to be found in subjective oral testimony. However, the reliability of service-user accounts of personal experience, as a source of evidence, has in the past been the

⁴⁹² Skidmore, P. 'EC Framework Employment Directive on Equal Treatment in Employment' (2001) 30(1) *Industrial Law Journal*, p. 126-8.

⁴⁹³ Previously, Oliver, M. (1996) *Understanding Disability: from Theory to Practice*; Hughes, B. & Patterson, K. (1997) The social model of Disability and the disappearing body: towards the sociology of impairment, *Disability in Society*; Imrie, R. (2004), Demystifying disability; a review of the International Classification of Functioning, Disability and Health, *Sociology of Health and Illness*, etc.

⁴⁹⁴ For example, The Information Centre, Mental Health Statistics. ISBN: 1-84636-110-9 London, HMSO. Which charts longitudinal trends in admissions; section 37 orders; the correlation between informal/formal "Revolving door patients" etc. The Office of National Statistics Report (2007). For Better or Worse, Office of National Statistics (2003) ISBN: 0-11-621658-1.

⁴⁹⁵ Computer Assisted Personal Interview.

⁴⁹⁶ Attitudes to mental illness 2009, Research Report JN 189997 May 2009, TNS UK.

subject of considerable criticism. As there are real issues relating to confidentiality and ethics during a patient's course of treatment, much of the oral evidence provided by service users themselves is by nature reminiscent rather than contemporaneous. Although this would seem to raise questions as to its value in terms of validity, as a methodology, there is a traditional and substantial body of social-medical research that has utilised qualitative analysis through semi-structured interview techniques and focus groups.⁴⁹⁷

What has emerged from recent studies is that there has been a shift in understanding the relationship between the Biomedical model of mental illness and a social model of disability.⁴⁹⁸ Whereas the traditional social theory of disability has been fettered by a structure that makes distinctions between the medicalisation of the body⁴⁹⁹ and the politicalisation of social impairment, many commentators⁵⁰⁰ now consider a more diverse approach where the notional embodiment of impairment can extend the disability dialogue to include the distress, both physical and emotional, caused by mental illness.

Whereas the conventional view of social disability theory has for the most part based its principles in that disability is a denial of civil rights caused by exclusionary practices, for example limited accessibility etc. Imrie⁵⁰¹ suggests that the social model of disability clearly differentiates between impairment⁵⁰² caused by disease, from disadvantage caused by social and environmental barriers, and as a consequence, attempts to de-medicalise disability. This perspective, with its functional emphasis, is widely supported internationally. The International Classification of Functioning, Disability and Health⁵⁰³ now considers all health and disease conditions on an equal footing irrespective of their cause, viewing disability and impairment as composite phenomena to

⁴⁹⁷ Goffman (1963), Resenhan (1973), Mulvaney (2000); Link & Phelan (2001) etc.

⁴⁹⁸ Lester, H. & Tritter, J.Q. 'Listen to my Madness': understanding the experiences of people with serious mental illness. *Sociology of Health and Illness*, Vol. 27 No. 5 2005 pp. 650-651.

⁴⁹⁹ Oliver, M. (1996) *Understanding Disability: from Theory to Practice*. Basingstoke, Macmillan.

⁵⁰⁰ Hughes, B. & Patterson, K. (1997) The social model of Disability and the disappearing body: towards the sociology of impairment, *Disability in Society*, Vol 12, 3, pp. 325-340.

⁵⁰¹ Imrie, R. (2004), Demystifying disability; a review of the International Classification of Functioning, Disability and Health, *Sociology of Health and Illness*, 26, 3, pp. 287-305.

⁵⁰² Impairment as a social construction rather than the 'impairment' defined in s.2, MHA.

⁵⁰³ ICF, WHO, (2001), *International Classification of Function Disability and Health*. Geneva, WHO.

which both individual and social factors are fundamentally inter-related. The inclusion of social factors as causative rather than as secondary issues does much to dispel the notion that disability can only be defined in absolute terms that separates the medicalisation of disabled peoples impairment from the politicalisation of their social environment. Moreover, separating illness into discrete diagnosis is problematic even when treatment is the aim. It initiates a predisposition to treat disease rather than people.

The re-assessment of the role of disability in mental health as a composite of social repression and impairment, as opposed to simply a subject restricted to medical or welfare issues, first gained importance in the late-1970's with the Disability Movement.⁵⁰⁴ Though much of the initial discourse was centred on physical impairment/disability, recent discussion has argued for a more flexible move towards including mental illness within the relative dialogue. When considered from this standpoint, any theory of disability, because of its complexity must out of necessity be interpreted beyond the physical manifestation of its condition. Furthermore, an interrelated model of understanding acknowledges the multiplicity rather than any singular identity as to what is defined as disability or impairment, thus recognising the significance and value of agency and empowerment within the debate.⁵⁰⁵

Conceptually, this post-modernist approach addresses the deficit of the physical loss (in addition to medical), in allowing service users to reclaim lost agency to overcome disadvantage. The acceptance of alternative methods of validation in the discussion suggests that the discourse should be engaged, not only from within the objectivity of the psychiatric profession but extended beyond the Biomedical model to encourage social narratives in their place.⁵⁰⁶

⁵⁰⁴ The Union of Physically Impaired Against Segregation, (UPIAS 1976) played a prominent role in the socio-political argument.

⁵⁰⁵ Shakespear, T. & Watson, N. (2002), The social model of disability: an outdated ideology, *Research in Social Science and Disability*, 2, pp.9-27.

⁵⁰⁶ Wilson, T. & Holt, T. 'Complexity and Clinical Care'. *British Medical Journal* 2001; 323, pp. 685-688.

Mulvany argues that establishing validity in such circumstances:

“...encourages the study of how people make sense of the bodily experience of insanity (the effects of the illness) without falling back on a biologically determinist view of madness...The concept of embodied irrationality provides a focus for a sociological contribution to the understanding of the complex relationship between biological and social factors.”⁵⁰⁷

Whereas the conservative aetiology of the biomedical model is somewhat limited to the behavioural histories of a particular disorder, the social disability model is concerned with the consequences of specific social arrangements in regard to the patients' circumstances. Models are abstract systems of broad-spectrum concepts, they are not theories in them selves, but they can help to generate theory and structure dialogue.

Adopting this broader approach has led to a wider use of narrative as a means of exploring not only personal but also social realities. As a result, including oral testimony within a broader framework of archetypal quantitative⁵⁰⁸ research has enabled a better understanding of the needs of service users, in contrast to the conservative discourse that is for the most part solely occupied with finding short-term answers to immediate problems. This is of significant importance in evaluating service user involvement as it allows the potential to discover subjective areas of evidence that are largely absent from written documentation, thereby shifting attention towards a more socio-spatial analysis of experience rather than the pragmatic reticence of Evidence Based Medicine (EBM).⁵⁰⁹ Nevertheless, EBM is important in making choices as to treatment[s], many patients are left feeling that their secondary concerns are forgotten and that they are little more than a disease being treated. There are of course two sides to the argument; the first involves a debate about the values, power and assumptions that underlie psychiatric

⁵⁰⁷ Mulvany, J. (2000) Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder, *Sociology of Health and Illness* Vol. 22, 5, p. 590.

⁵⁰⁸ “Better or worse”: a longitudinal study of the mental health of adults carried out by the Office of National Statistics every 3 years since 2001 using a revised Computer Interview Schedule (CIS-R); Lewis *et al* (1992) Measuring psychiatric disorder in the community: a standardized assessment for use by lay interviewers. *Psychological Medicine* 22 pp. 465-486.

⁵⁰⁹ Sackett, D.L. *et al.* (1996) Evidence based medicine: what it is and what it isn't. *BMJ* 312 (7023), 13 January, pp. 71-72.

treatment. The second includes listening to the concerns of service users, through user-orientated research.⁵¹⁰ Both issues have been addressed in part, with the establishment of strategic bodies such as the National Institute for Clinical Excellence (NICE), whose remit includes a more homogenous approach to best practice. Although there has been criticism that the emphasis on cost effective healthcare in context, has been marred by commercial interest and political interference in the interest of reducing National Health Service expenditure, in particular the cost of prescribed medication and its relative effectiveness. The development of consultative bodies such as the National Institute for Mental Health and the Mental Health Foundation has been established with the aim of actively involving service users experience and opinions as factual resources. Furthermore, successful lobbying by stakeholders has led to the inclusion in the 2007 MHA that psychiatrists and hospital managers are required to inform patients of all treatment[s] that are available and the right to advocacy services.⁵¹¹

Recent research has indicated that the inclusion of oral testimony has helped to identify new areas of evidence for further study. Significantly, the realisation that benefits and disadvantages of intervention of psychiatric treatments should include information relating to non-clinical indicators of the quality of life lived, as well as conventional health outcomes is gaining approval. This has been the case in general nursing since the 1980's with the introduction of Activities of Living Conceptual Care models which consider a more interrelated approach including contributory factors that influence the activities of living rather than clinical indicators alone.⁵¹²

Although a considerable number of studies have examined the quality of life of mainstream patient groups or general population samples, very few have

⁵¹⁰ Bracken, P. & Thomas, P. (2000) Putting ethics before effectiveness. *Open Mind*, 102, p. 22.

⁵¹¹ NHS Confederation briefing 171, (September 2008), *Implementing the Mental Health Act 2007*. London, the NHS Confederation.

⁵¹² Roper, N. Logan, W. & Tierney, A. (2000), *The Roper-Logan-Tierney Model of Nursing: Based on Activities of Living*; London, Churchill Livingstone.

focused on people with mental illness.⁵¹³ Only a minority of studies to date have compared Quality of Life (QoL) in general populations with common mental disorders and severe mental illness. The importance, and benefits, of involving service users in the research process has been stated by the Department of Health in 2001⁵¹⁴ and more recently in 2005 in support of the *National Framework for Long-term Conditions*, which stated that service user involvement:

‘...reflects the value placed on the opinions of people who use services and their families/carers, as well as the views of professionals...and is based on the principle that qualitative, quantitative and mixed studies can have equal validity when used in the appropriate context.’⁵¹⁵

This endorses a position that has long been sanctioned by charitable bodies such as Mind and the Sainsbury Centre.⁵¹⁶ Although there is clear guidance for the researcher and the consumer,⁵¹⁷ little has been written about the impact of this involvement. Much of the existing research involving consumers or service users looking at the advantages, disadvantages, or value of user involvement in research rather than the effectiveness of such research on services or service users.⁵¹⁸

A recent review of the literature suggests there is no clear consensus on either the type or level of consumer involvement in health care.⁵¹⁹ Nonetheless, a number of writers have argued the importance of integrating service user narrative alongside evidence-based medicine in furtherance of a

⁵¹³ Ruggeri, M. Bisoffi, G. Fontecedro, B. S. *et al* (2001) ‘Subjective and objective dimensions of quality of life in psychiatric patients: a factor analytic approach’. *British Journal of Psychiatry* Vol. 178, pp.268-275.

⁵¹⁴ Department of Health (2001b), Health and Social Care Act 200, Department of Health, London.

⁵¹⁵ Department of Health (2005a), *National Framework for Long-term Conditions*, Department of Health, London.

⁵¹⁶ Rose, D. (2001), *Users Voices; The Perspective of Mental Health Service Users on Community and Hospital Care*, London, Sainsburys Centre for Mental Health.

⁵¹⁷ Consumers in NHS Research Support Unit (2001), *Getting Involved in Research: A Guide for Consumers*, Consumers in NHS Research Support Unit, Eastleigh

⁵¹⁸ Faulkner, A. and Thomas, P. (2002), “User-led research and evidence-based medicine”, *The British Journal of Psychiatry*, Vol. 180, pp. 1-3.

⁵¹⁹ Telford, R., Beverley, C.A., Cooper, C.L. and Boote, J.D. (2002), “Consumer involvement in health research: fact or fiction?,” *British Journal of Clinical Governance*, Vol. 7 No. 2.

more holistic approach to healthcare.⁵²⁰ Acknowledging service users views through a disability model may have practical as well as theoretical benefits. Just over 10 per cent of the working-age population covered by the DDA in the UK have a mental health problem⁵²¹ yet the DRC found that people with mental health problems are among the least likely to win DDA claims.⁵²² Whilst further labeling may on the face of it appear to be counter productive, if people with serious mental illness are unable to engage in the discourse, they may remain unaware of the protection offered by the DDA. Promoting a discussion around recognising and owning the potentially disabling effects of impairment might prove helpful in both raising users' awareness of their rights and in placing the disadvantages faced by people with serious mental illness within the broader framework of the Disability Movement.

More recently, the employment of mental health services users within the NHS as Support Time and Recovery Workers⁵²³ offers a more positive example of the utility of the social model of disability. The new role acknowledges the importance of work as a mechanism for enabling greater social inclusion and recognises the value of first hand experience as an essential requirement for the post. The Department of Health has also included lived experience as a desirable requirement for the role of the primary care mental health worker.⁵²⁴ Direct Payments, part of the UK Government's policy response to calls from disabled groups for greater independence and control over their own support systems, represents a practical strategy for managing impairment and disability. The Government's *Pathways to Work*⁵²⁵ initiative, which promotes employment for people

⁵²⁰ Brown, W. & Kandirikirira, N. (2006), *Recovering mental health in Scotland. Report on narrative investigation of mental health recovery*, Glasgow: Scottish Recovery Network. Also Roberts, G. & Wolfson, P. (2006) 'New directions in rehabilitation: learning from the recovery movement', in Roberts, G. Davenport, S. Holloway, F. & Tattan, T. (eds) *Enabling Recovery; The principles and practice of rehabilitation psychiatry*, London: Gaskell, Chapter 2.

⁵²¹ Office of National Statistics: *Labour Force Survey Oct – Dec 2007*. London: HMSO.

⁵²² Levertson, S. (2002) *Monitoring the Disability Discrimination Act 1995*. London: HMSO.

⁵²³ Department of Health (2003a) *Mental Health Policy Implementation Guide. Support, Time and Recovery Workers*. London: Department of Health.

⁵²⁴ Department of Health (2003b) *Fast-forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers: Best Practice Guidance*. London: Department of Health.

⁵²⁵ Pathways to Work is a program run by Job centre Plus.

http://www.direct.gov.uk/en/DisabledPeople/Emloymentsupport/WorkSchemesAndProgrammes/DG_

receiving Incapacity Benefit, includes a *Choice Package* that aims to help people manage the symptoms and effects of their illness so they are better able to find work (Social Exclusion Unit 2004). The proposal, in effect, recognises the correlation between disability and impairment beyond the disabling consequences of the symptoms themselves.

The increased growth of volunteering schemes recognises the importance of non-medicalised provision and the inclusion of service users' own unique set of skills as part of the discussion.⁵²⁶ Nonetheless, although there is evidence that charitable organisations such as Mind, Sane and the Shaw Trust⁵²⁷ (among the many) play an important part in workplace procurement and social inclusion, there are still concerns that whilst the position of mental health service users within services has improved, the overall economic framework is still one of marginalisation and social exclusion within the community.

4.7 Conclusion

From a service users point of view being treated for a mental illness is a perilous journey fraught with risk. For most patients, help is accessed through a visit to the local GP with a small number of patients requiring referral to specialist services. Recognising that there is a problem is for many service users and their families', a difficult first step to negotiate. It is at that point that the reality of a cumbersome body of regulation - that to a certain extent relies on passive compliance - begins to make itself felt. It is this small group of service users that are the most vulnerable and are most at risk of detention or restriction under the MHA.

The moment that the patient begins to engage with the MHA, the potential for loss of autonomy is endorsed proportionally, the further the patient enters into the psychiatric system, the more rigorous and controlling the system becomes. The MHA is distinctive in that it is one of the few pieces of

171745http://www.direct.gov.uk/en/DisabledPeople/Employmentsupport/WorkSchemesAndProgrammes/DG_171745.

⁵²⁶ Social Exclusion Unit (2004) *Mental Health and Social Exclusion*. London. HMSO.

⁵²⁷ <http://www.shaw-trust.org.uk/home>.

legislation that may deprive an individual of his liberty, however, unlike other forms of incarceration, the risk of detention fundamentally remains one of medical paternalism rather than the judicial system *per se*. Consequently, unlike the doctor patient relationship in mainstream physical health care that is for the most part one of beneficence, the doctor patient relationship in psychiatry is inevitably overshadowed by the spectre of latent coercion. Though the 2007 MHA Code of Practice places considerable emphasis on ‘the least restrictive course of action’ and ‘service user participation at all stages of treatment’, the decision making process is still very much based on medical paternalism.

Many service users experience a range of emotions and responses to hospitalisation, ranging from uncertainty and anxiety, overcrowding in inadequate facilities to intimidation and fear of violence and sexual assault. Recent amendments of the 2007 MHA Code of Practice now provide that children will no longer be placed in adult psychiatric wards, a long awaited move that many commentators such as the Mental Health Alliance have lobbied for for many years.

Though the Commissioners Twelfth report is highly critical of in-patient services, particularly of some metropolitan psychiatric units with occupation rates exceeding 100%, and that there had been a substantial failure to act on the recommendations of the Eleventh Biennial Report, it should however be noted that many of the residential units inspected were rated as excellent. Nonetheless, the Thirteenth and final report (the first since the MHA 2007 Act), is critical that inadequate in-patient facilities and under-resourced community teams are still key issues in need of improvement. It is patently obvious that for many service users both formal and informal, in-patient psychiatric care and community support remain very much a postcode lottery. Viewed from an economic standpoint, it is likely that the use of Community Treatment Orders is likely to increase as less resources are available, giving considerable weight to the argument for ‘*principled*’ legislative

inclusion,⁵²⁸ of a 'right' to safe and supportive treatment and resources including substantive aftercare. This is of real concern in providing the necessary mechanisms to operate the new CTO's, one of the most contentious changes introduced by the new MHA.

Adopting an objective approach to mental health recovery based on social constructs of impairment would provide a greater degree of latitude in providing access to available service providers. Recent data⁵²⁹ suggests that only 3.5% of service users known to LA's (through care plans) are in paid employment compared with 7.5% of individuals with learning difficulties in similar circumstances. Since 2004 the Labour Government through the Office of the Deputy Prime Minister has acknowledged that social exclusion is one of the major obstacle towards recovery. The Coalitions consultations process *No health, without mental health*,⁵³⁰ has service user participation as one of its core aims. Subsequently there have been a number of positive moves to promote equality. *Shift*, the Government's recent consultative document had user participation, as it's central theme, indicating that there is an appreciable move towards user led recovery. Nonetheless, a significant number of service users continue to be reliant on NGO's for long-term assistance in the community.

The next Chapter will continue on the theme of social reconstruction and explore some of the more robust economic arguments for a grass-roots approach to future reform rather than the continuing reliance on 'top-down' regulation.

⁵²⁸ As opposed to the Code of Practice.

⁵²⁹ Social Care and Mental Health Indicators from the National Indicator Set –further analysis 2008-09. Leeds, The Health and Social Care Information Centre. NI 150 (National Indicator): The proportion of adults in contact with secondary mental health services in employment, pp. 25-28.

⁵³⁰ HMG/DH, (02 Feb 2011), *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*, London: TSO.

Chapter 5. Towards further reform

Introduction:

As discussed in Chapter One, the genealogical effect of the historical development of statutory mental health regulation as we see it today has been largely restricted within the boundaries of an institutional pathway. Only recently with the 2007 amendments to the 1983 legislation has there been a more positive move towards post psychiatric recovery with the much broader approach underpinning the use of supervised community treatment, though limited contextually within the confines of the Act itself.

As argued in Chapter Two, the amendments to the 1983 legislation provided by the 2007 Act have created a range of positive safeguards,⁵³¹ which should be considered in terms of Political and Civil (PC) rights. There has however, been little within the revisions to suggest an improvement in Economic, Social and Cultural rights (ESC). This should not be measured as a failure on the part of Government to address the importance of third wave rights,⁵³² only that there are limitations inherent within the traditional institutional construction of mental health and community services,⁵³³ which fail to fully challenge social exclusion, stigma and discrimination, both in the delivery of services and in the context of a wider society.

As is the nature of any procurement exercise, whether it is for the competitive purchasing of materials in the manufacturing sector, or the commissioning of

⁵³¹ As discussed in Chapter 2, for example, Part II, MHA, s26-34, Changes to the functions of relatives of patients, including civil partnerships. Part IV, s58A Consent to treatment (specifically, Electro Convulsive Therapy). Part VIII, s117. The use of after-care in the community, particularly regarding patients on Community Treatment Orders (s17A-G). Part X, s130, The right to independent advocacy (IMHA), etc.

⁵³² Carpenter argues that, first wave rights grew during the eighteenth century with a shift towards liberalism in the treatment of the mentally ill, rather than the custodial approach that had previously been the norm. Second wave rights emerged following the Second World War with the ECHR and in particular the founding of the NHS and the first steps towards community care. For further reading see Carpenter, M. (2009), 'A third wave, Not a Third Way: New Labour, Human Rights and Mental Health in a Historical Context. And, Klug, F. (2001), 'The Human Rights Act - a "third way" or "third wave" Bill of Rights,' *European Human Rights Law Review*, (4). pp. 361-372.

⁵³³ Primary care by G.P.'s, informal care/hospitalisation and out-patient services, crisis management, formal admission, discharge and aftercare as required under s117, MHA 1983.

services by government departments, expenditure is inevitably a question of how best to manage finite resources. Within the current climate of budgetary deficit, the UK having entered a period of recession, where reducing government spending has become central to future policy in addressing the budgetary deficit. Hence, the contemporary position for service commissioners is increasingly one of economic necessity being reconciled with prudent expenditure. In addition, there are other factors that to a lesser or greater extent, will impact upon future services and reforms.

Following the end of the National Health Service Framework for Mental Health,⁵³⁴ the then Labour Government commissioned a strategic consultation process into the future commissioning of services⁵³⁵ that adopted a much broader approach towards the provision of mental health care. With a change of government following the 2010 general election, the Coalition, mindful of the Comprehensive Spending Review,⁵³⁶ also commissioned a research document⁵³⁷ to assist policymakers in the provision of future mental health services.

This chapter will consider how ESC rights, such as the eradication of social exclusion, discrimination and stigma can be extended beyond the remit of the MHA 2007 and how this may be achieved in view of the current economic situation. Firstly, what is the economic cost of mental illness? This section will discuss the current and projected costs of direct care from two perspectives: the overall economic cost and the social cost. Secondly, is there a place for wider participation and cooperation with NGO's in mental health care? Finally, is the apparent move towards a more democratic sharing of power among stakeholders, indicative of a long-term paradigm shift towards a more holistic approach to mental health care?

⁵³⁴ DoH, National Health Service Framework for Mental Health, Sept 2009.

⁵³⁵ DoH, (23rd July 2009), *New Horizon: Towards a shared vision of mental health*, London, TSO.

⁵³⁶ http://www.hm-treasury.gov.uk/spend_index.htm.

⁵³⁷ Department of Health, (April 2011) *Mental health promotion and mental illness prevention: The economic case*. DoH, London. The report was the result of collaboration between researchers in the Personal Social Services Research Unit (PSSRU), London School of Economics and Political Science; the Centre for Mental Health (CMH); and the Centre for the Economics of Mental Health (CEMH), Institute of Psychiatry at King's College London.

5.1: The economic cost of mental illness

The number of people in contact with NHS specialist mental health services has been slowly rising over a number of years. Data from the NHS Mental Health Bulletin⁵³⁸ showed that in the year 2007-2008 1,190, 542 people were seen by specialist psychiatric services, an increase of 3.4% on the previous year. This equates for the general population as one person in fifty. Women accounted for 56% of the total number,⁵³⁹ an increase consistent with the findings of the 2007 Adult Psychiatric Morbidity Survey carried out in 2007,⁵⁴⁰ which indicated that generally, women's mental health has been deteriorating, with a greater number being diagnosed with depression and anxiety than in previous surveys. Approximately one in eleven people in contact with secondary mental health services spent some time as inpatients, with one in three of those patients being subject to compulsory detention under the MHA. The survey also found that some minority groups were over represented, with 18.9% coming from Black or British Black ethnic groups. Nonetheless, it can be seen that the financial impact of mental ill health is considerable.

In a policy document commissioned by the Sainsbury Centre for Mental Health in 2003,⁵⁴¹ the overall cost of mental illness to the economy was put at £77.4 billion, with the outlay broken down as follows:

- The costs of health and social care, covering such costs as the services provided by the NHS and local authorities for people suffering from mental health problems: £12.5 billion.

⁵³⁸ Mental Health Bulletin. Second report on experimental statistics from the Mental Health Minimum Dataset (MHMDS) annual returns 2003-2008 24th March 2008, The Mental Health and Social Care Information Centre. Table 1, p.10.

⁵³⁹ *Ibid.*, Women were more likely than men to have a CMD (Common Mental Disorder) (19.7% and 12.5% respectively), and rates were significantly higher for women across all categories of CMD, with the exception of panic disorder and obsessive-compulsive disorder. See Table 2, p.11.

⁵⁴⁰ *Adult Psychiatric Morbidity Survey, 2007, Results of a household survey*, The Information Centre for Health and Social Care. Published January 27th 2009. Data collected through the Clinical Interview Schedule – Revised (CIS-R). The CIS-R is an interviewer administered structured interview schedule covering non-psychotic symptoms in the week prior to interview. It can be used to provide prevalence estimates for 14 types of neurotic symptoms, six types of CMD, and a continuous scale that reflects the overall severity of neurotic psychopathology.

⁵⁴¹ SCMH Policy Paper Three, (2003b) *The Economic and Social Cost of Mental Illness*.

- The costs of output losses in the economy, which result from the negative impact of mental illness on an individual's ability to work: £23.1 billion.
- The human costs of mental illness, corresponding to the adverse effects of mental illness on the health-related quality of life: £41.8 billion.⁵⁴²

Similarly, a review in 2008 by the Kings Fund, *Paying the Price*⁵⁴³ put the cost of health and social care at £22.5 billion in 2007, rising to £47.48 billion in 2026 and the cost of lost output at £26.1 billion in 2007 rising to £40.97 billion in 2026.⁵⁴⁴ The report estimated that 35% of those with depression and 51% of those with anxiety disorders were not in contact with services, and that many conduct disorders and eating disorders, particularly among children and adolescents were undiagnosed and untreated.⁵⁴⁵

Although not currently the largest demographic group of people with mental disorders, as a result of an increasingly ageing population, particularly amongst people aged 75 and over, elderly patients with dementia⁵⁴⁶ will see the largest increase in numbers,⁵⁴⁷ The service costs associated with the long term care and treatment of dementia are anticipated to be far higher than all other conditions put together. At the time of the Kings Report, it was estimated that 582,827 people suffered from late onset dementias,⁵⁴⁸ at a cost of £4.9

⁵⁴² *Op. cit.* Policy Paper Three, (2003b) I. Table 1.

⁵⁴³ McCrone, P. Dhanasiri, S. Patel, A. Knapp, M & Lawton-Smith, S. (2008), *Paying the Price: The cost of mental health care in England to 2026*. London The Kings Fund.

⁵⁴⁴ *Ibid.*, Table 1 p. 18.

⁵⁴⁵ *Ibid.*, Executive Summary xix.

⁵⁴⁶ Dementia is a general term for loss of memory and other mental abilities severe enough to interfere with daily life. It is caused by changes in the brain. Alzheimer's disease is the most common form of dementia, accounting for 50 to 70 percent of cases. Other types of dementia include vascular dementia, mixed dementia, dementia with Lewy bodies and frontotemporal dementia. www.alz.org/alzheimers/. Accessed 22nd December 2008.

⁵⁴⁷ *Ibid.*, Table 3, p. 11. Figure 3, of the report, which shows that those aged 75 to 84 and 85+ are demographically increasing in number at a greater rate than those in other age groups.

⁵⁴⁸ *Ibid.*, p. 114.

billion *per annum*.⁵⁴⁹ By 2026 it was estimated that this would increase to 937,636,⁵⁵⁰ people, costing £34.8 billion *per annum*,⁵⁵¹ an increase of 61%.

The Kings Fund review provided estimated future costings of mental health problems in England until 2026, based on the analysis of eight separate categories of mental disorder, the estimated costs associated with those conditions and the impact that specific interventions may have on those costs. Whilst the authors stated that the data in the report was a representative estimate of the costs of mental health disorders, they also acknowledged that there were a number of limitations.

Although much of the data collected on the prevalence of mental disorders was obtained from a mixture of national surveys and published literature; they were not able to obtain good estimates of how prevalence rates could change over time.⁵⁵² Data on service use and costs was also limited. One area where the costs were underestimated was for forensic mental health care. For example, the cost data for schizophrenia was obtained from community studies and whilst inpatient data statistics were obtained from the Hospital Episode Statistics⁵⁵³ these would not have accounted for stays in private sector secure units.

The authors also recognised that there were limitations within the intervention modeling in estimating future costs, with many scenarios limited to those interventions, such as Cognitive Behavioral Therapies (CBT), for which there was data on effectiveness. However, the report emphasised that that there were some areas of intervention, such as vocational based models of recovery where there was little existing empirical evidence supporting such models and recommended more research into the cost-effectiveness of a

⁵⁴⁹ Department of Health, (April 2011) *Mental health promotion and mental illness prevention: The economic case*. DoH, London. Fig 1, p1.

⁵⁵⁰ *Ibid.*, p. 114

⁵⁵¹ *Ibid.*, Fig 1, p. 1.

⁵⁵² Psychiatric Morbidity Surveys of 1993 and 2000 show little change in prevalence rates, epidemiologists consulted generally did not feel that rates were changing, with the exception of dementias. p. 117.

⁵⁵³ Hospital Episode Statistics 2004/5. Information supplied by the NHS Information Centre, 2007. p. 138, (Specialty Code: Adult Mental Illness-710).

range of interventions, including mental health promotion and prevention initiatives.⁵⁵⁴

The Kings Report's authors stressed that if new strategies for effective prevention, early diagnosis and intervention across the full spectrum of mental health conditions were not at the forefront of reform, the cost of treatment will continue to escalate.⁵⁵⁵ This suggests that there needs to be shift in recognising that mental health is not just an individual problem (something to be subjectively treated), but also a social problem (something to be objectively recognized and prevented), with a much wider impact than was previously thought.

Nevertheless, data collected from reports such as the SCMH, the Social Exclusion Unit, and the King's Report illustrate a more positive attitude on the part of policy makers to shift some of the responsibility of providing mental health care away from the traditional service areas of the medical profession over to a more integrated and collaborative approach including third sector and ancillary service providers.

One of the Kings Report's authors, Martin Knapp,⁵⁵⁶ stated in a national newspaper that:

"The hope would be that, along with other reports on mental health, such as the stuff Mind did recently on the link between debt and poor mental health, the cumulative effect will be for the government to act. We are on the right track. The government has actually been experimenting with ways to make different parts of the public sector work together, such as individual budgets for social care, but what is needed is a recognition of how a more joined up approach might work for something like mental health which has multiple dimensions."⁵⁵⁷

⁵⁵⁴ *Op.cit. Paying the Price*, p. xxi.

⁵⁵⁵ *Op. cit.* p. 19.

⁵⁵⁶ Martin Knapp is Professor of Health Economics and Director of the Centre for the Economics of Mental Health at the Institute of Psychiatry, King's College London. He is also Professor of Social Policy and Chair of LSE Health and Social Care at the London School of Economics.

⁵⁵⁷ *Cited*, Mary O'Hara, The Guardian, Wednesday 28 May 2008.

5.1 (2): New Labour and *New Horizons*

As the National Service Framework for Mental Health was drawing to a close, the then Labour Government published a consultation strategy to map the future of mental health services for the future. As opposed to previous strategies based for the most part on empirical reviews of costs, *New Horizons*,⁵⁵⁸ as a consultation exercise adopted a much broader approach in moving towards a more eclectic position in both its purpose and its approach. The Executive Summary, stated that:

“The programme takes a life-course approach, from laying down the foundations of good mental health in childhood through to maintaining mental resilience into older age; from prevention of mental health problems, through effective treatment to recovery”⁵⁵⁹

The *New Horizons* programme had two key aims:

- Improving the mental health and well-being of the population, and
- Improving the quality and accessibility of services for people with poor mental health.

As part of the consultation process, a number of key issues emerged. As opposed to the treatment and provision of the care of mental illness itself as a central tenet; *New Horizons* proposed that future services identified the need to prevent and promote mental health and well-being generally as well as the treatment of mental health problems *per se*. It also focused on social inclusion to tackle stigma and discrimination and the use of early intervention strategies to improve long-term outcomes. In addition, *New Horizons* strongly advocated a broader approach to achieving multi-agency commissioning and collaboration between local authorities, the NHS and others.

The movement in policy direction towards a vision of good mental well being as an objective social norm, rather than something that affected a small minority of people (the mentally ill), has gained further recognition following a

⁵⁵⁸ DoH, (23rd July 2009), *New Horizon: Towards a shared vision of mental health*, London, DoH.

⁵⁵⁹ *Ibid.*, p. 7.

report produced by the Government Office for Science (GO-Science). The *Foresight Mental Capital and Well-being Project*⁵⁶⁰ was specifically aimed at policy makers and highlighted the importance of a multi-dimensional approach to strategic policy planning.

In the foreword, John Denham, the then Secretary of State for Innovation, Universities and Skills, stated:

“The Project has shown that Government is already on the right track in many areas. However, it also demonstrates that there is very considerable scope to go further by adopting a long-term and strategic perspective that spans an individual’s life course. Realising the full benefits could have implications for systems of governance of mental capital and well-being and for how the decisions on trade-offs for resource allocation are made. Nevertheless, the report identifies a number of priority areas, where more immediate benefits could be realized.”⁵⁶¹

While not a paradigm shift *per se*, the report gave considerable weight to the argument that good mental health is not just about treating the individual, it also impacts on the wider society.⁵⁶² In economic terms, there are considerable gains to be made in realising mental health expenditure through positive long-term promotion and intervention, rather than short-term solutions to immediate problems.

The report stated that:

“Whilst it is important for Government to address problems that affect the mental development of specific groups, such as learning difficulties and mental disorders, policies and choices also need to nurture the mental capital and well-being in the wider population, so that everyone can flourish throughout their lives.”⁵⁶³

⁵⁶⁰ *Foresight Mental Capital and Well-being Project (2008), Final Project Report*, The Government Office for Science, London.

⁵⁶¹ *Op. cit.* p. 5.

⁵⁶² A position long supported by many service user groups and NGO’s, for example, The Future Vision Coalition, <http://www.newvisionformentalhealth.org.uk/>. Friedli, L. (2009), *Mental Health, Resilience and Inequalities*, WHO Regional Office for Europe. Among the many, etc.

⁵⁶³ *Op.cit.* p. 10.

Investment in good public health brings obvious benefits, not only to the individual but also to society as a whole; by referring to mental capital⁵⁶⁴ as an objective social construction, the authors highlighted the importance of 'joined up' mental healthcare. Contextually, the findings of the report sought to objectively redefine strategic planning as a multi-dimensional mechanism of policy within a broader perspective.

A key conclusion of the Go-Science report was that objective investment in mental capital and individual mental well-being are inherently connected; policies that address the one will often affect the other.

5.1 (3): Future policy under the Coalition Government.

The recent change of government following the 2010 general election has seen the Conservative & Liberal Democrat Coalition continue Westminster's commitment to equality in mental health care, albeit, against the backdrop of financial recession and the *Comprehensive Spending Review*.⁵⁶⁵ Following the *New Horizons* consultation exercise, the Coalition Government commissioned a number of strategic policy documents for both main-stream health care (*Health Lives, Healthy People*),⁵⁶⁶ and mental health services specifically (*No Health, Without Mental Health*).⁵⁶⁷

Andrew Lansley, the Secretary of State for Health, stated in the foreword of *No Health, Without Mental Health*, that:

"...the Coalition Government's success will be measured by the nation's wellbeing, not just by the state of the economy. The public health White Paper *Healthy Lives, Healthy People* is the first public health strategy to give equal weight to both mental and physical health. This Government recognises that our mental health is central to our quality of life, central to our

⁵⁶⁴ The Report explains Mental Capital as: "An individual's mental capital and mental well-being crucially affect their path through life. Moreover, they are vitally important for the healthy functioning of families, communities and society. Together, they fundamentally affect behavior, social cohesion, social inclusion, and our prosperity." p. 10.

⁵⁶⁵ Cm 7942, October 2010, <http://www.official-documents.gov.uk/>

⁵⁶⁶ Department of Health (2010) *Healthy Lives, Healthy People: Our strategy for public health in England*, available at: <http://tinyurl.com/healthyliveshealthyPeople>. Accessed January 5th 2011.

⁵⁶⁷ HMG/DH, (02 Feb 20011), *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*. www.dh.gov.uk/mentalhealthstrategy. Accessed April 20th 2011.

economic success and interdependent with our success in improving education, training and employment outcomes...”

Broadly similar in objectives to the *New Horizons* strategy, the proposals within *No Health, Without Mental Health*, have been welcomed for the most part, though with some misgivings by stakeholders.

Simon Lawton-Smith of the Mental Health Alliance, stated in his response that:

“We welcome the new acknowledgement that mental health is a public health issue that needs cross-departmental co-operation. Issues such as education, social care, housing, employment and welfare are as important in tackling mental health as health services... it is noticeable that there are few solid financial commitments made. However well-meaning it is, this strategy will only prove successful if adequate funding is provided in the right areas, across all relevant national and local government departments.”⁵⁶⁸

The publication of the report comes at a time of major transition in the provision of local health services. The Government’s proposals to reform the NHS, through the Health and Social Care Bill 2011⁵⁶⁹ will undoubtedly have long-term implications for the way local services are provided and funded.⁵⁷⁰ In addition to the *No Health, Without Mental Health* project, the NHS, commissioned a report from the Personal Social Services Research Unit (PSSRU), and the London School of Economics,⁵⁷¹ to research the effectiveness and projected costs of future mental health strategies in England based on intervention.

Across the border in Wales, the position differs to that in England. Whereas the *National Service Framework for Mental Health* in England ran its course in

⁵⁶⁸ The Mental Health Alliance’s response to *No Health Without Mental Health*. (2nd February 2011) <http://www.mentalhealth.org.uk/our-news/news-archive/2011/2011-02-02/>. Accessed April 21st 2011.

⁵⁶⁹ The Bill proposes to create independent NHS Boards, promote patient choice, and to reduce NHS administration costs. <http://services.parliament.uk/bills/2010-11/healthandsocialcare/documents.html>. Accessed 22nd April 2011.

⁵⁷⁰ The reorganisation of NHS Wales, which came into effect on October 1st 2009, has created single regional health organisations that are responsible for delivering all healthcare services within a geographical area, rather than the Trust and Local Health Board system that existed previously.

⁵⁷¹ Department of Health, (April 2011) *Mental health promotion and mental illness prevention: The economic case*. DoH, London.

2009, the Welsh Assembly Government implemented its own *National Service Framework*⁵⁷² in 2002, later revised⁵⁷³ as '*Raising the Standard*' the revised adult mental health National Service Framework and an Action Plan for Wales in 2005. As a consequence, there has been some chronological overlap in the strategic delivery of services. In the interim, the amended MHA 2007 received royal assent, covering both England and Wales. There have also been significant changes in the way in which strategic health care is now delivered in Wales through the implementation of the regionally based Local Health Boards replacing the smaller 22 Local Health Boards (LHBs) and seven NHS Trusts that had existed since 2003.⁵⁷⁴

Currently, the Welsh Assembly Government has implemented the Mental Health (Wales) Measure 2010,⁵⁷⁵ which addresses the continuing development of the Mental Health Framework in Wales, with particular emphasis on the establishment of a standardised Care Plan Approach.

These distinctions were noted in the *No Health, Without Mental Health* policy document's executive summary, which stated that:

"While this strategy is specific to England, the challenges are common across the four countries of the United Kingdom. We will work closely with the Devolved Administrations in Northern Ireland, Scotland and Wales, recognising their particular and varying responsibilities. Each will consider the most appropriate arrangements to address the issues in ways that meet their own circumstances and needs."⁵⁷⁶

⁵⁷² Welsh Assembly Government, April 2002.

⁵⁷³ Wales Audit Office, (2004), "*Baseline Review of Mental Health Service Provision in Wales*." The review undertaken by the Wales Audit Office during 2004 found that mental health professionals struggled with the implementation of the NSF, and progress towards ensuring that each local area had access to the full range of services set out in the Strategy was slow. http://www.mentalhealthwales.net/mhw/framework_wales.php Accessed 23rd June 2011.

⁵⁷⁴ The Public Health Wales National Health Service Trust (Membership and Procedure) Regulations 2009, S.I. 2009 No. 1385 (W.141).

⁵⁷⁵ Received Royal Approval 15th December 2010.

⁵⁷⁶ *No Health, Without Mental Health*, (2011), para 1.4 p. 5.

As the Mental Health (Wales) Measure 2010 addresses similar proposals⁵⁷⁷ contained in the *No Health, Without Mental Health* policy document, it is anticipated that future developments will continue along the same lines.

Although much of the primary data used in the preparation of costs for the PSSRU Report was based upon previous research carried out by the Kings Fund in 2008,⁵⁷⁸ the PSSRU Report differed significantly in its approach to previous studies. Whereas *Paying the Price* focused primarily on the cost of treating specific mental disorders and projected cost saving interventions relating specifically to those disorders, the PSSRU Report adopted a much wider approach. Firstly it sought to identify and evaluate the costs and economic pay-offs of a much wider range of interventions.⁵⁷⁹ Secondly, the economic analysis for each intervention was designed so as to produce a comprehensive breakdown of costs and pay-offs, year by year, by individual sector and budget type. Interventions could therefore be examined from two separate perspectives; firstly, pay-offs to society as a whole, and secondly, budgetary impacts in the NHS and other public sector agencies.

The fifteen interventions modelled ranged from early intervention for psychosis, promoting well-being in the workplace, to debt and mental health, The design allowed the data to be expressed contextually as three distinct categories of outcome:

⁵⁷⁷ Although in some instances the Welsh Measure is more specific regarding certain criteria of intervention, for example Key Action 6 is aimed at collaboration between the new LHB's and local authorities provision of access to non-statutory advocacy services, having earlier identified a gap in services highlighted by the Welsh Audit Office in 2004.

⁵⁷⁸ *Paying The Price*. London: King's Fund, 2008, cited *Mental health promotion and mental illness prevention: The economic case* p 1 Table 1.

⁵⁷⁹ Department of Health, (April 2011) *Mental health promotion and mental illness prevention: The economic case*. DoH, London 2.1 Health visiting and reducing post-natal depression, p. 4. 2.2 Parenting interventions for the prevention of persistent conduct disorders, p. 6. 2.3 School-based social and emotional learning programmes to prevent conduct problems in childhood, p. 9. 2.4 School-based interventions to reduce bullying, p.12. 2.5 Early detection for psychosis, p. 14. 2.6 Early intervention for psychosis, p. 16. 2.7 Screening and brief intervention in primary care for alcohol misuse, p. 18. 2.8 Workplace screening for depression and anxiety disorders, p. 20. 2.9 Promoting well-being in the workplace, p. 22. 2.10 Debt and mental health, p. 24. 2.11 Population level suicide awareness and training, p. 26. 2.12 Bridge safety measures for suicide prevention, p. 29. 2.13 Collaborative care for depression in individuals with Type II diabetes, p. 31. 2.14 Tackling medically unexplained symptoms, p. 33. 2.15 Befriending of older adults, p. 36.

- Short-term returns on investment (year 1): economic pay-offs per £1 of expenditure
- Medium-term returns on investment (years 2–5): economic pay-offs per £1 of expenditure and;
- Long-term returns on investment (year 6 onwards): economic pay-offs per £1 of expenditure

The report concluded that:

- Even though the economic modelling is based on conservative assumptions, many interventions are seen to be outstandingly good value for money⁵⁸⁰
- A number of interventions are self-financing over time, even from the narrow perspective of the NHS alone. However, the scope for ‘quick wins’, in the sense of very short payback periods for the NHS, is relatively limited.⁵⁸¹
- Many interventions have a broad range of pay-offs, both within the public sector and more widely (such as through better educational performance, improved employment/earnings and reduced crime).⁵⁸²
- Many of these interventions are already NHS responsibilities, but the analysis also highlights opportunities for the NHS to work closely in partnerships with other organisations and in jointly funded programmes.⁵⁸³

⁵⁸⁰ Department of Health, (April 2011) *Mental health promotion and mental illness prevention: The economic case*. DoH, London p. 43.

⁵⁸¹ *Ibid.*, pp. 43-44.

⁵⁸² *Ibid.*, pp. 43-44.

⁵⁸³ *Ibid.*, pp. 43-44.

- Many interventions are very low cost. A small shift in the balance of expenditure from treatment to prevention/promotion should generate efficiency gains.⁵⁸⁴
- In some cases the pay-offs are spread over many years. Most obviously this is the case for programmes dealing with childhood mental health problems, which in the absence of intervention have a strong tendency to persist throughout childhood and adolescence into adult life. However, the overall scale of economic pay-offs from these interventions is generally such that their costs are fully recovered within a relatively short period of time.⁵⁸⁵

Although not all of the interventions modelled would show immediate returns in cost effectiveness, for example, for every £1.00 spent on early detection of psychosis, in the short-term, would amount to a negative gain in the first year of –£1.00 however, after 6 years the projected long-term gain would equate to an economic pay-off of 1.88 per £1.00 invested.⁵⁸⁶ The economic analysis empathised in the report suggested that, over and above any gains in health and quality of life through wider access to services, the use of such a broad range of interventions would generate considerable economic benefits. For example, increased productivity through less time lost through illness, a reduction in the level of incapacity benefits and higher treasury returns collected through taxation and VAT.

The PSSRU report is more diverse in its approach towards future spending on mental health, its fundamental theme is one of pro-active intervention and collaboration between the NHS, and services delivered by voluntary, charitable and independent (private sector for profit) organisations. For example, interventions aimed at school age children could involve a multi-

⁵⁸⁴ *Ibid.*, pp. 43-44.

⁵⁸⁵ *Ibid.*, p. 43.

⁵⁸⁶ Department of Health, (April 2011) *Mental health promotion and mental illness prevention: The economic case*, Table 14, p. 40.

agency approach from local education authorities, local social services departments, PCT's and possibly the voluntary sector.

The report illustrates positive gains in adopting a pro-active approach rather than a reactive response towards future services deployment, nevertheless, against a background of proposed spending cuts it may be difficult to initiate in the current economic climate. There is however a cautionary note, both the SCMH and the Kings Report provided conservative projections for the cost of future expenditure on mental health services until the year 2026.

In its conclusion, the Kings Report (2008b) summarised that:

"The current service cost (£22.5 billion) is equivalent to 1.7 per cent of the Gross Domestic Product (GDP). The projected cost for 2026 including real changes in prices (£47.5 billion) is equivalent to 3.5 per cent of GDP. If we consider total costs (that is including lost employment), currently the cost of these mental health problems (£48.6 billion) are equal to 3.6 per cent of GDP, rising to 6.6 per cent (£88.5 billion) by 2026 with real changes in prices and earnings included. We need to be somewhat cautious with these figures as the costs of mental health care include unpaid informal care which is not typically included in GDP".⁵⁸⁷

Both the SCMH and the Kings Report based their projections on current spending trends continuing unchanged and allowed for growth at 2% above the rate of inflation including the real pay and price effect. The Kings Report, in its conclusion suggested that there were two major factors that would influence the future cost of services, firstly:

"There would need to be a medical breakthrough in terms of the treatment (and even 'cure') of some, or all, of the disorders, leading to prevalence rates dropping. However, past experience suggests that the continuing progress made in terms of better, more effective treatments, with fewer side-effects, has had little or no impact on overall prevalence rates. Perhaps the area with most potential is that of dementia, where the development of new drugs that slow the progress of dementia and allow people to remain living independently with minimal informal or formal support, could have a substantial impact on costs."⁵⁸⁸

⁵⁸⁷ Kings Fund (2008b), *Paying the Price*, p. 119.

⁵⁸⁸ *Op. cit.* p. 122

And secondly:

“...the establishment of effective mental health promotion and prevention strategies and practice.”⁵⁸⁹

Although the SCMH and the Kings Report differed in their methodologies from the PSSRU Report, they came to broadly similar conclusions regarding the future economic sustainability for mental health services until the year 2026. From an economic perspective, in order to ensure that future expenditure can be strategically employed at sustainable levels, priority should be given to increased investment in pro-active intervention strategies. Although in the short-term this would lead to an increase in expenditure, in the long-term, early intervention strategies could provide considerable budgetary savings, particularly in the treatment of the more high-risk category of patients. Adopting early intervention as the focus for future spending could provide both positive gains in the long-term health and an improvement in the quality of life for service users. Arguably, in addition to the long-term budgetary savings, which are anticipated by adopting proposals that are focused on early intervention and prevention, the real benefits of such policies would be to address some of the underlying issues that contribute to the social cost of mental illness.

5.2: The Social cost of mental illness.

It is well established that mental illness has a number of adverse effects on the level of domestic economic activity; people with mental health problems are less likely to be in paid employment than those without such problems.⁵⁹⁰ They often have fewer qualifications and find it harder to both obtain and stay in work,⁵⁹¹ have lower incomes, are more likely to be homeless or poorly housed, and are more likely to live in areas of high social deprivation.⁵⁹² Their

⁵⁸⁹ *Ibid.*, p. 122.

⁵⁹⁰ Skapinakis P, Weich, S et al (2006) Socio-economic position and common mental disorders. Longitudinal study in the general population in the UK. *British Journal of Psychiatry* 189:109–117.

⁵⁹¹ Meltzer h, Bebbington P, Brugha T et al. (2010) “Job insecurity, socio-economic circumstances and depression.” *Psychological Medicine* 40(8): pp. 1401–1407.

⁵⁹² Cooper R, Boyko c and Codinhoto R (2008), The effect of the physical environment on mental well-being. *Mental Capital and Wellbeing Project*. London: Government office for science.

spells of unemployment are typically longer in duration. Among those in paid employment more time is taken off work for health reasons, additionally, people with mental illness are more likely to suffer from physical ill health than others. Research has suggested that lost productivity through absence from work because of mental health problems will account for an estimated £40.97 billion, nearly half of the estimated £88.45 billion total cost of mental health in 2026.⁵⁹³

Many people with a history of mental illness are fearful of disclosing their illness to employers over worries about job security and status. As one recovering patient put it:

“We’re not accepted when we go back, no matter that you can do the job...they don’t treat you as an equal, they’re always a bit wary”⁵⁹⁴

The relationship between poor mental health and economic exclusion is now well understood, however, The Social Exclusion Unit’s report *Mental Health and Social Exclusion*, found that less than one in ten employers would consider employing a person with a history of mental illness.⁵⁹⁵ One third of people with mental health problems have reported that they had been dismissed or forced to resign from their jobs. Four out of ten believed that they had been denied a job because of their previous psychiatric history, and over two-thirds had been reluctant to apply for jobs because of fear of unfair treatment.⁵⁹⁶

Despite several high profile campaigns, stigma and discrimination continue to be pervasive in the job market. Unfortunately, there appears to be an urban folklore about the mentally ill and employment:

⁵⁹³ *Op.cit. Paying the Price*, p. 121.

⁵⁹⁴ Warner, L. *Out of Work: A Survey of the Experiences of People with mental Health Problems in the Workplace*, Mental Health Foundation (2002), cited *Mental Health and Social Exclusion: Social Exclusion Unit Report* (2004), Office of the Deputy Prime Minister, London, HMSO, p. 27.

⁵⁹⁵ *Mental Health and Social Exclusion: Social Exclusion Unit Report* (2004), Office of the Deputy Prime Minister, London, HMSO, pp. 27-29.

⁵⁹⁶ *Ibid.*, p. 27.

- ‘*they cant work*’ A large number of people with mental illness can hold down a job with the right kind of support.
- ‘*they don’t want to work*’ many people with mental illness would wish to return to work.
- ‘*they can’t make decisions*’ Many successful people in all walks of life have had mental health problems.⁵⁹⁷

From discussion in the previous Chapter it is clear that many people with mental health problems see employment as a vital and continuing part of the recovery towards mental well being. Exclusion results in loss of self-esteem and confidence that make it difficult to return to the job market, Research indicates that claimants who move off benefits and re-enter work generally experience improvements in income, socio-economic status, mental and general health, and well-being. However it also shows that “those who move off benefits but do not enter work are more likely to report a deterioration in health and well-being.”⁵⁹⁸

The King’s Report (2008)⁵⁹⁹ recognised the therapeutic value as well as the economic value in helping people back into the job market. Among their many recommendations the authors suggested that:

“We know, though, that employment (including voluntary work, part-time work and paid work) can bring great benefits to individuals experiencing mental health problems in terms of self-esteem, personal income and quality of life, and these are strong reasons for improving training and employment... Primary care trusts should commission more evidence-based interventions in primary care settings for people with depression and anxiety disorders, and providers should aim to treat more people who have these disorders but currently do not receive treatment...The reduction in lost employment costs should outweigh the cost of increased service provision...”⁶⁰⁰

⁵⁹⁷ Grove, B. (1999) “Mental health and employment: Shaping a new agenda.” *Journal of Mental Health*, 8, pp. 131-140.

⁵⁹⁸ Waddell, G. and Burton, A.K. (2006), *Is work good for your health and well-being?* London, TSO

⁵⁹⁹ *Paying the Price*, (2008).

⁶⁰⁰ *Ibid.*, pp. 121-128.

The then Labour Government recognised that employment was a fundamental part of recovery with the introduction of Public Service Agreement (PSA) 16 in the 2008- 2011 Comprehensive Spending Review.⁶⁰¹ In addition, there were several government initiatives aimed at supporting employees in the workplace.⁶⁰² For example, the *Pathways to Work Scheme*⁶⁰³ had specific aims in assisting people who receive support allowances or incapacity benefits to return to work using an individually tailored approach designed specifically for the person taking part in the program. The program also makes extensive use of the expertise provided by NGO's and the voluntary sector.

From an individual standpoint, the personal cost of mental illness is reflected in the likely loss of income and the additional burdens placed on other family members and carers. The potential knock-on effects can be pervasive; there is evidence of an association between problem debt and mental health problems, with one in two adults with debt having mental health problems, and one in four adults with mental health problems being in debt.⁶⁰⁴ Such burdens often extend well beyond the primary locus; divorce is more prevalent in families where mental illness is present, with the subsequent separation often leading to a further deterioration in mental well-being.⁶⁰⁵ Family breakdowns inevitably place additional pressures on third party stakeholders, local social services departments, homeless charities and other NGO's and the Criminal Justice System are frequently engaged to a greater or lesser degree, all of which inevitably contribute to the extended social cost of dealing with mental illness.

⁶⁰¹ PSA16 provides targets for local authorities for increasing employment and settled housing for people who use secondary mental health services.

⁶⁰² The Cabinet Office (Dec 2009) "*Work, Recovery and Inclusion: employment support for people in contact with secondary mental health services*" London, TSO.

⁶⁰³ Pathways to Work was a three year national back-to-work programme available to all customers claiming incapacity benefits and Employment and Support Allowance (ESA) in Great Britain. Started 28th April 2008, ended 31st March 2011.

⁶⁰⁴ Fitch, C. Hamilton, S. *et al*, *Debt and Mental Health: What do we know? What should we do?* (2009) Rethink, Royal College of Psychiatrists, Money Advice Trust, FLA, p. 1.

⁶⁰⁵ Harris, R. Hardy, R. Wadsworth, M. (1997), "The effects of divorce and separation on mental health in a national UK birth cohort," *Psychological Medicine*, (1997), 27: pp. 1121-1128.

The SCMH (2003) report⁶⁰⁶ made the point that a *per capita* approach in reviewing economic output was unsuitable when applied to human cost because of the difficulty in putting a monetary value on the adverse effects that mental ill health may have on the quality of life. Instead the SCMH report used an application based on the QALY⁶⁰⁷ approach in ascribing a monetary value to individual loss. Though the analysis and interpretation of both the King's and SCMH's reports findings are beyond the scope of this thesis, the SCMC's Report suggested at the time that the personal human cost of mental illness was around five times the cost of the services provided by the NHS and local authorities.⁶⁰⁸ The reports authors did however make the point that the report was based on data collected through the *Adult Psychiatric Morbidity Household Survey* and as such, contained little data on those patients that were subject to long-term hospitalisation, those that were in prison or those patients that had effectively "*dropped out of the system.*"

The King's Report suggested that its estimates of projected costs were at best conservative, with much of the future expenditure forecasts dependant on the willingness of stakeholders to establish local initiatives.

All of the reports considered noted the difficulties in assessing the impact of hidden costs through lack of adequate data, for example, the effect of reduced consumer spending both to the individual and to the economy. Nonetheless, it is clear that people with mental health problems remain one of the most economically excluded groups in society. A recent report by the West Midlands Observatory found that among those experiencing mental health problems, only 29% were in employment, compared to 61% of those with any health problem, and 72% for the general population.⁶⁰⁹

The economic cost to society as a whole is considerable, with increasing numbers of people turning to mental health services for help, the cost is going

⁶⁰⁶ SCMH, Briefing 22, (2003), "*A Summary of Money for Mental Health: A review of public spending on mental health care*" London: The Sainsbury Centre for Mental Health. Accessed 14th July 2008.

⁶⁰⁷ Quality Adjusted Life Years.

⁶⁰⁸ SCMH Policy Paper Three, (2003) *The Economic and Social Cost of Mental Illness*, p. 8.

⁶⁰⁹ West Midlands Regional Observatory, Mental Health and Employment in the West Midlands: Briefing Paper September 2009. www.wmro.org, Accessed 12th July 2010.

to increase proportionally. Fortunately, recent trends indicate that there is a growing emphasis on providing long-term socially constructed solutions rather than short-term re-active responses.⁶¹⁰

From a rights perspective, the objective recognition that stigma and the absence of social inclusion strategies⁶¹¹ have been significant barriers to some patients accessing mental health services is a positive gain in ESC rights. Although the arguments for better education aimed at combating stigma and social exclusion have been around for some time,⁶¹² in practice, with one or two exceptions,⁶¹³ previous initiatives have for the most part been ineffective.⁶¹⁴ The Kings Fund Report noted that expenditure on mental health promotion accounted for 0.1% of the total distribution of NHS spending on mental health services in 2006/7.⁶¹⁵

How this can be addressed in the current economic climate of spending cuts and the proposed changes to localised service delivery will inevitably prove difficult in the short term. Paul Jenkins, the Chief Executive of the mental health charity Rethink, when asked to comment by the on-line forum Public Finance, made the following statement:

“Historically, mental health services have been a soft touch for cuts. But it’s completely false logic to ratchet that into the future. There’s no greater resilience in mental health services than in acute services’... ‘When there’s a lot of pressure on public spending, mental health illness is something crying out for money to be driven into treatment rather than cut out because it

⁶¹⁰ HMG/DH, (02 Feb 2011), *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*, London, TSO.

⁶¹¹ The effect of labelling, the associated stigmatisation attached to mental illness and the reluctance of some patients, particularly BEM’s was previously discussed in Chapter 4 at some length.

⁶¹² *Mental Health and Social Exclusion: Social Exclusion Unit Report* (2004), Office of the Deputy Prime Minister, London, HMSO.

⁶¹³ Scottish Executive, (2003). *National Program for Improving Mental Health and Well-Being*. Edinburgh: Scottish Executive. <http://www.scotland.gov.uk/Publications/2004/12/20443/48925> Accessed 14th November 2009.

⁶¹⁴ The Welsh Audit Office Report (2004), *"Baseline Review of Mental Health Service Provision in Wales."* Noted that there were significant local differences in accessing support services in Wales, particularly in north and mid Wales.

⁶¹⁵ The Kings Fund, *Paying the Price*, (2008), Pie chart 1, p. 1.

will save money elsewhere...More radical thinking is necessary if we are going to pull off dealing with the debt problem and the need for appropriate support and treatment.”⁶¹⁶

The costs of direct care⁶¹⁷ fall to Strategic Health Authorities in England and the new regional Local Health Boards in Wales, with Local Authority Social Services Departments absorbing much of the cost of secondary care, with additional support by the third sector. Should wider participation by NGO's become more commonplace as policy progresses, the fiscal cost of future intervention strategies would be distributed amongst a larger number of stakeholders. Although in the short-term, some of the strategic interventions under proposal⁶¹⁸ may result in an initial deficit before long-term gains are materialised within NHS budgets, there are additional benefits to be gained by wider participation in multi-agency collaboration that will accrue elsewhere. These would be realised through increased employment and productivity, tax revenue, VAT and reduced benefits payments. Furthermore, many of today's NGO's are proficient fund-raisers with a great deal of flexibility in how they are able to provide services and expertise.⁶¹⁹ For service users, a more equitable distribution of resources aimed at prevention and social inclusion would in the long-term provide significant gains in ESC rights, particularly when those resources are distributed according to local service user need through NGO participation. Furthermore, a shift in commissioning services provided by service user orientated stakeholders in collaboration with other interested parties will provide considerable opportunity for social inclusion and empowerment.

5.3 The continuing role of NGO's in mental health care

For most of the twentieth century mental health policy was for the most part the preserve of central government, essentially a top-down approach administered by civil servants and implemented by the medical profession.

⁶¹⁶ <http://www.publicfinance.co.uk/news/2010/04/mental-health-services-are-soft-target-for-cuts/>
Accessed, 28th May 2011

⁶¹⁷ G.P.'s, Hospital care, Out patients units etc.

⁶¹⁸ “*No health, without mental health*” and the PSSRU Report.

⁶¹⁹ http://www.mind.org.uk/Campaigns_issues_time_to_change/community_projects accessed 20th Dec 2009.

With the closure of the old asylum system⁶²⁰ and the implementation of care in the community as a central component of government mental health policy, mental illness gained considerable public exposure, with local authorities playing a central part in the development of community services alongside local voluntary organisations.⁶²¹

Many of today's charitable NGO's, originating from their early beginnings as local self-help groups, have by contrast grown from local user campaign lobbyists to become major participants in the making of policy.⁶²² The number of local community groups engaged in providing services and shaping mental health policy as a realistic grass-roots alternative to mainstream services has been the subject of considerable expansion, particularly among black and ethnic minority groups.⁶²³ At the most fundamental level, many of the groups are user-led self-help groups that meet informally once or twice a month, and are often run locally by the voluntary sector. In view of this, the cost of these services has little or no effect on local authorities budgets, though most local authorities engage to some extent, for example, allowing service user groups the free or subsidised use of local community facilities.

Mind, one of the leading mental health charities, has been proactive in breaking down barriers against discrimination by running a campaign of 28 local community activity projects involving service users, local authorities and members of the local community.⁶²⁴ Mind also runs local drop-in centres and work closely with local authority social services departments and other interested stakeholders. Similar initiatives are also in place at local levels, the Afiya Trust in North London for example. Following a report reviewing Children's and Adolescent Mental Health Services (CAMHS), it was found that:

⁶²⁰ *A Hospital plan for England and Wales*. London, HMSO, 1962. Cmnd 1604.

⁶²¹ Turner, N Roberts, G. "The Worcester Development Project" *The British Journal of Psychiatry* 160: pp. 103-107 (1992).

⁶²² The Mental Health Alliance is a coalition of 75 organisations working together to secure better mental health legislation and rights for mental health patients. <http://www.mentalhealthalliance.org.uk>.

⁶²³ The Afiya Trust, <http://www.afiya-trust.org/>, Awaaz <http://www.awaaz.co.uk/mentalhealth.htm>, among several.

⁶²⁴ http://www.mind.org.uk/Campaigns_issues_time_to_change/community_projects accessed 20th Dec 2009.

“The overall picture is that mainstream public services and programmes, with some notable exceptions, are failing to meet the mental health needs of BME children and young people. They are more likely to come to the attention of services at the point of crisis, yet there appears to be no significant progress in redressing this injustice.”⁶²⁵

That the report was able to access the opinions of young BEM service users (aged 11-25 yrs) illustrates the positivism of local engagement with minority groups that for the most part are excluded by mainstream consultation.⁶²⁶

Other voluntary organisations such as the Citizens Advice Bureau (CAB) provide free and independent advice in 751 GP surgeries and health centres, 62 general hospitals, 75 psychiatric hospitals and 165 mental health clinics. In addition, since 2003 the Department of Health has funded the CAB to provide Independent Complaints Advocacy Service (ICAS) services in six of nine health regions in England and there are 116 ICAS specialists based in 32 bureaux. The CAB runs local advice projects⁶²⁷ specifically for people with mental health problems in over 100 Bureaus advising on debt, housing, employment and benefit entitlements.⁶²⁸

That local accessibility is now an increasingly important issue is in part due to a 2006 policy paper by the SCMH,⁶²⁹ where the Local Government Association, the NHS Confederation, the SCMH and the Association of Directors of Social Services collaborated in producing a report outlining what mental health services should be like in the future and identifying two key areas:

⁶²⁵ Malek, M. (2011), *Enjoy, achieve and be healthy: The mental health of black and minority children and young people*. London, The Afiya Trust.

⁶²⁶ The Afiya Trust campaigns not only on mental health issues but also on other health problems where many BEM groups would seem to be excluded, possibly for cultural reasons, for example, as part of their current campaign the Afiya Trust and Race on the Agenda (ROTA) have prepared a response to the Coalition Government's White Paper on public health, *Healthy Lives, Healthy People*. http://www.afiya-trust.org/images/files/other/afiya_rota_response.pdf. Accessed July 10th 2011.

⁶²⁷ Authors note, each CAB Bureau is run as an independent charity with local need as part of its agenda.

⁶²⁸ http://www.citizensadvice.org.uk/campaigns/social/cosultation_responses/healthcomcare/mental-health-social-exclusion. Accessed 13 December 2009.

⁶²⁹ SCMH, (2006), *The Future of Mental Health, a vision for 2015*.

- Look at where services are located and how accessible they are to the people who need them.
- Examine how health and local government work together with the voluntary and independent sectors.

The New Horizons consultation process actively engaged with service users and other organisations in devising the new strategy to replace the existing national service framework.⁶³⁰ With the specific aims of better integration with Royal Colleges, health care professionals, third sector organisations and local government in providing leadership at both national and local levels, the Consultation Paper sought advice from a larger sector of interested parties than any previous consultation exercise. Although it is as yet early days, *New Horizons'* successor, *No Health, Without Mental Health* has set out a strategic action plan⁶³¹ that has cross departmental cooperation and collaboration with NGO's as its central theme.

The effects of the voluntary sector's cooperation with local services should not be underestimated; the following case study is taken from the Social Exclusion Units report and illustrates the benefits of NGO involvement:

"Ude had been in prison and had spells in hospital with severe mental health problems. He was referred to the First Step Trust in Lambeth, which provides work projects for people with mental health problems and other disabilities or disadvantages...At First Step Trust, Ude discovered that he had a flair for organising people and managing small teams of workers on site and in the community...He has recently been appointed to a salaried position and manages the gardening section, which is the project's largest commercial contract with an annual income of £90,000. *"I had to get my life together,"* says Ude, *"and I did it through work."*⁶³²

⁶³⁰ Department of Health, *New Horizons, a Shared Vision for Mental Health*. (2009) HMSO.

⁶³¹ HMG/DH, (02 Feb 2011), *No Health Without Mental Health: A cross-government mental health outcomes strategy for people of all ages*, Annex B, pp. 81-85.

⁶³² Office of the Deputy Prime Minister *Mental Health and Social Exclusion: Social Exclusion Unit Report* (2004), London, HMSO p. 10.

5.3(2) The future for participation by NGO's.

From various reports, both from government and other stakeholders, it is clear that the future of an integrated mental health care system is going to be one of increasing co-operation. However the level of service user and NGO involvement varies from locality to locality;⁶³³ for example, the Mental Health Foundation is currently involved in a collaborative project, *Principles of Self-management*,⁶³⁴ with Cardiff University and MDF, the Bi-Polar Organisation, with funding provided by the National Lottery. The project organized 60 self-help workshops at venues across Wales, with a target audience of 900 people. The project drew upon existing expertise by recruiting service users as trainers, and anticipated that this would be the first of many such programmes that would contribute towards the further development of evidence based practice and would be applicable to a wide range of disorders in the future.

The role of many NGO's involved in mental health has undoubtedly changed radically over the last twenty-five years. As opposed to being seen as a collective of survivors' movements protesting against what was known at the time as psychiatric oppression,⁶³⁵ they are now regarded as equals with other organisations and provide considerable input in helping to determine future policy and research.

The Mental Health Alliance,⁶³⁶ which has over seventy members, was undoubtedly the driving force behind many of the positive gains made during the parliamentary process of the MHA 2007. Alongside other third sector organisations (such as private sector service providers), mental health NGO's were active participants in the consultation process leading to the new MHA

⁶³³ Local difficulties in accessing services was one of the key findings in the Welsh Audit office Report,

⁶³⁴ The Mental Health Foundation, *Principles of Self-management*, Jan 2009-2012. www.mentalhealth.org.uk/our-work/recovery/self-management-wales/ accessed Dec 28 2009.

⁶³⁵ Authors note: Foremost authors who contributed towards the Anti-psychiatric movement include Michel Foucault in France, R. D. Laing in Great Britain, Thomas Szasz in the United States, and Franco Basaglia in Italy.

⁶³⁶ <http://www.mentalhealthalliance.org.uk/>

2007,⁶³⁷ the *New Horizons* Strategy and its Coalition successor, *No Health Without Mental Health*.

At a regional level, where many voluntary organisations have the greatest impact, policy makers have recognised the contributions that local services providers make to local communities. Changes to the Office of the Deputy Prime Minister, now the Department for Communities and Local Government,⁶³⁸ and the implementation of the Sustainable Communities Act 2007⁶³⁹ continued an objective movement towards grass-roots policy-making in implementing services according to local need. John Denham, the then Secretary of State for Communities and Local Government urged councils to sign up to community contracts, stating that:

"...community contracts are an important way for local people to tell councils and agencies what matters to them and to get action on the issues that matter most to them. The new guidance and support will make it easier for local residents and service providers to get involved"⁶⁴⁰

Somewhat controversially, the Coalition have put forward the Health and Social Care Bill⁶⁴¹ which in part, intends to devolve the provision of local health care through the formation of General Practitioner Commissioning Consortia⁶⁴² and local commissioning bodies. Though not directly related to mental health as such, the broader remit of the Dept for Communities and Local Government has advocated robust support for voluntary organisations and other relevant services including cooperative partnerships with NGO's.

⁶³⁷ Mind, (DMH 210) (DMH 400), Rethink, (DMH 192), the Mental Health Alliance, (DMH 105) (DMH 382) all submitted evidence to the Joint Committee on the Draft Mental Health Bill.

⁶³⁸ <http://www.communities.gov.uk/corporate/>

⁶³⁹ The Sustainable Communities Act received Royal Assent on 23 October 2007. The aim of the Act is to promote the sustainability of local communities.

⁶⁴⁰ Press briefing from the Communities and Local Government Organisation, Jan 3rd 2010.

⁶⁴¹ The Bill had its Second Reading debate on 31 January 2011 and was committed to a Public Bill Committee. The Committee last considered the Bill on 31 March 2011.

⁶⁴² Laja, Sade. The Gaurdian, Friday 1 April 2011, Health secretary Andrew Lansley, announced that: "Today we can announce that 90% of the country is now covered by groups of GPs who are best placed to deliver better care for patients. This uptake from the grassroots is very encouraging and means that nine out of 10 people in England will start to see the benefit of more personalised care."

Further developments within this growing theme of extending local authority accountability and spending within local communities, is one of the central tenets of the Localisation Bill.⁶⁴³

“Chapter 3 enables voluntary and community bodies, charities, parish councils or public sector employees delivering the service, to express an interest in running a local authority service. Where it accepts an expression of interest, the local authority must carry out a procurement exercise for the running of that service”⁶⁴⁴

This implies that the further distribution of ESC rights remains high on the political agenda. This is significant in context to local communities and service users. Many NGO's, as well as having national policy strategies, also maintain very strong local networks, thus recognising that local need and particularly the needs of local service users are given an effective forum in how the services that matter to them are delivered locally. Projects such as the Mind/University of Cardiff's *Principles of Self-management*,⁶⁴⁵ workshops not only benefit service users through research and knowledge transfer, they also give service users a voice.

5.4 Is the apparent move towards a more democratic sharing of power among stakeholders indicative of a long-term paradigm shift?

As discussed in Chapter One, many of the stakeholders had varying aspirations as to what would be achieved by amending the 1983 MHA, in practice, due to the existing institutional nature of the pre-existing legislation and concerted cross-bench opposition towards the previous two draft bills, the parliamentary process of the 1983 Act essentially became one of revision.

⁶⁴³ As brought from the House of Commons on 19th May 2011 [HL Bill 71]. The Bill will devolve greater powers to councils and neighbourhoods and give local communities more control over housing and planning decisions. The Bill proposes (among several other initiatives) to give communities a “right to challenge” council-run services. If a community group, social enterprise or parish council expresses interest in taking over a council service, the local authority will have to consider their bid and, if it is rejected, publish the reasons. Accessed 24th April 2011.

<http://services.parliament.uk/bills/2010-11/healthandsocialcare.html>. Accessed 24th April 2011.

⁶⁴⁴ <http://www.publications.parliament.uk/pa/bills/lbill/2010-2012/0071/en/2012071en.htm>. Accessed 9th June 2011.

⁶⁴⁵ Previously discussed above.

However, substantial scope for advancing the rights of all groups exists through the shift to positive duties, which has initiated a move away from requiring individuals to press grievances in order to obtain a remedy through the legal system (negative rights), towards more positive gains through implied ESC rights. This is beginning to manifest itself in two ways. Firstly there are several new positive duties gained within the new act, for example the right to advocacy and improved social care, which place statutory obligations on providers (as discussed previously).⁶⁴⁶

Secondly the subtle shift in the direction of government policies towards community engagement, notably the *New Horizons* strategy framework, and its replacement *No Health, Without Mental Health* may yet provide a more concrete opportunity to promote equality, diversity, empowerment and well-being as part of strategic planning aside from the MHA itself. It is the second of these that may provide a greater opportunity for a more democratic level of participation in addressing ESC rights for service-users.

In the *New Horizons* foreword, the then Secretary of State for Health John Denham stated that:

*"New Horizons: a shared vision for mental health sets out a unique dual approach. It combines service improvement with a new partnership of central and local government, the third sector and the professions with the aim of strengthening the mental health and well-being of the whole population. This is about more than preventing mental illness, important though that is; it is also about helping individuals and communities to bring the best out of themselves, with all the health, social and economic benefits that follow."*⁶⁴⁷

As previously discussed, the report identified two fundamental aims, firstly, the prevention of mental health and secondly, the promotion of mental health well-being. In moving from a re-active to a pro-active position regarding prevention, it opens the possibility of social gains in imposing collective obligations on organisations, including local government.⁶⁴⁸ *New Horizons*

⁶⁴⁶ Chapter 2. pp.55-65.

⁶⁴⁷ Department of Health, *New Horizons: a shared vision for mental health*, 7th December 2009, p. 5.

⁶⁴⁸ For example, at a subjective level, the inclusion of a broader remit of interested parties/stakeholders in the preparation of service user care plans.

implied a move in the direction of a broader and more utilitarian approach towards reform than the previous National Service Framework. This thematic shift is in part further underpinned by the growth of anti-discrimination laws enacted towards gender, race, disability, sexuality orientation, age, religion; and belief and the creation of the Equalities and Human Rights Commission.

Viewed in this context, the *New Horizons* consultation has recognised that mental well-being within society as a whole, was a fundamental component of future Government strategy.

As well as the two core aims, the *New Horizons* document pinpointed a number of key strategic issues:

- Early intervention
- Tackling stigma
- Strengthening transitions
- Personalised care and
- Innovation.

And proposed that:

“...effective strategies to tackle these themes would be provided through multi-agency commissioning and collaboration in achieving value for money. Nonetheless, acknowledging that the cost-effectiveness of interventions would remain critical, service improvements would have to be self-financing, evidence-based, and reflective of local commissioning needs.”⁶⁴⁹

Recognising that multi-agency collaboration is an essential part of policy opens up new possibilities for service delivery, particularly when addressing local needs. Research has identified that those with low incomes who live in deprived neighbourhoods are more likely to suffer from poor mental health; the rate of compulsory admission under the MHA tends to be higher in socially deprived areas.⁶⁵⁰ Scotland, with some of the worst areas of urban poverty in

⁶⁴⁹ *Op. cit.* p. 10

⁶⁵⁰ Stafford, M. & Marmot, M. “Neighbourhood deprivation and health: does it affect us all equally?” *Int J Epidemiol.* 2003 Jun;32(3): pp. 357-66.

the UK,⁶⁵¹ has made considerable advances in mental health prevention with its three-year *National Programme for Improving mental health and well-being*,⁶⁵² The project had two aims: to change the way in which people think and act about their own mental health and that of others; and to improve the quality of life of those affected by mental illness. The programme's action plan states:

"Being able to provide the basic building blocks of a good quality of life in local communities is an essential part of improving mental health and well-being. This involves the provision of good quality housing, quality built environments, environmental policies that have communities' well-being at the core of their actions, good transport infrastructure, safe parks and recreational areas and facilities, cultural activities, play areas, clean streets, responsive policing, tackling speeding and drug dealing."⁶⁵³

The Scottish Government as part of its implementation of *National Programme for Improving Mental Health and Well-Being* also commissioned an independent organisation to advise on strategy.⁶⁵⁴ It then subsequently embarked on a campaign of a series of television and community workshops involved in addressing social exclusion, discrimination and stigma. The 'See Me' Campaign, although originally a central government concept, through robust marketing expanded to include health groups, local authorities, local education authorities, NGO's and local businesses across Scotland, with a process of continuous revision helping to evaluate the progress of the campaign. That 'See me' was able to operate effectively at both national and local levels is an example of shared empowerment, which integrated service users with other stakeholders into key roles to address local issues and target specific groups.

⁶⁵¹ <http://www.scotland.gov.uk/Topics/Statistics/Browse/Social-Welfare/TrendPoverty>. The Scottish Household Survey (SHS) has shown that since 1994/5 poverty in urban areas has consistently remained above the national average of 15%.

⁶⁵² Scottish Executive, (2003). *National Program for Improving Mental Health and Well-Being*. Edinburgh: Scottish Executive. <http://www.scotland.gov.uk/Publications/2004/12/20443/48925> Accessed 14th November 2009.

⁶⁵³ *Ibid.*, <http://www.scotland.gov.uk/Publications/2003/09/18193/26509>, Accessed 14th November 2009.

⁶⁵⁴ Previously discussed in Chapter 3. The professional communications agency Citigate SMARTS was chosen from a number of invited tenders to provide a comprehensive design and delivery package to support the campaign team

As an example, the Scottish experience has much to commend it; the programme was seen as innovative in moving away from a direct top-down approach from Central Government to more sustainable long-term solutions that benefit from a wider participatory base of expertise, part of the rationale being, that the effect on those involved continues long after the campaign itself has finished. The Scottish Development Centre for Mental Health has continued in the same vein indicating its commitment to working in partnership with others to achieve better mental health for individuals, families and communities as priorities for 2008-2011.⁶⁵⁵

As the Scottish programme suggests, effective prevention strategies need to encompass a wide range of issues including public education, access to support systems, information sharing and the involvement of a wide range of interested stakeholders if they are to be effective. This multi-dimensional approach was a key point in the *New Horizons* consultation process, more investment in community programmes would be necessary as a future strategy; the consultation document stated that:

“Local councils are at the heart of providing locally responsive and better value services. Local government has a strong role to play in ensuring the delivery of public sector entitlements and in the greater scrutiny of service providers and the quality of their services. Good cross-sector leadership requires the active participation of all stakeholders, including users, families, carers, frontline staff and the public.”⁶⁵⁶

Other preventative measures proposed, included better local primary care at the point of entry; inequalities in access to health services can prevent vulnerable groups from receiving appropriate treatment and support,⁶⁵⁷ better support for carers groups and families and educating the raising the general publics’ awareness of mental illness.

⁶⁵⁵ <http://www.sdcmh.org.uk/> Accessed 12 December 2011.

⁶⁵⁶ Department of Health, *New Horizons: a shared vision for mental health*, 7th December 2009, p75.

⁶⁵⁷ For example, the Afiya Trust’s campaign on behalf of young BEM children and adolescents, as previously discussed.

It would seem that the *New Horizons* consultation exercise intended to continue much of the work started by the Social Exclusion Unit, with a wider cross-departmental remit. Many of the stakeholders responded positively. Su Sayer, Chief Executive of United Response, commented on the *New Horizons* initial consultation document, stating that:

"New Horizons, is a bold and positive step towards reform of mental health services in the UK. Its collaborative approach is particularly welcome: by involving people with mental health needs, the NHS and service providers from the start, the consultation is far more likely to lead to a successful new strategy that reflects and addresses the reality of living with mental health needs in the UK."⁶⁵⁸

Responses from other commentators was a little more cautious; *Minds* Chief Executive Mike Farmer stated in a press release that:

"New Horizons has broken new ground by setting out irrefutable evidence that improving mental health lies in considering the impact of every aspect of our physical and social environments, and is the responsibility of government both locally, nationally, and across all departments. Now that this benchmark has been set, it represents a turning point that no new government can turn back from. Good mental well-being isn't just about treatment, it's also about prevention, and by focusing on the factors that take their toll on our well-being in the first place, we have a chance at achieving better mental health for everyone."⁶⁵⁹

He did, however, make the point that in many areas, essential mental health services are still below par. Improvements in general well-being and in mental health services are necessary, but it is essential to make sure that one does not happen, at the expense of the other.

It would seem that the Coalition Government intends to continue with the concept of *grass-roots* participation as a policy theme central to its *Big Society* agenda.⁶⁶⁰ The PSSRU report and the *No Health, Without Mental Health* strategy document both argue for extensive investment in wider intervention strategies and acknowledge that collaboration with third party stakeholders will be an essential requisite for the success of future mental health policy. The

⁶⁵⁸ Press release United Response, 24th July 2009, <http://www.unitedresponse.org.uk/press/response-new-horizons.htm>, Accessed 21st October 2010.

⁶⁵⁹ Mind Press release 7th December 2009, www.mind.org.uk. Accessed 9th December 2009.

⁶⁶⁰ <http://www.cabinetoffice.gov.uk/content/big-society-overview>. Accessed 5th January 2011.

objectives as outlined within the *No Health, Without Mental Health* strategy, in collaboration with other cross-departmental initiatives that are in progress, could offer significant gains in how NGO's within the third sector operate in the future. Rather than being seen as recipients of funding, the possibilities of greater participation in working partnerships could give NGO's a greater stake in policy decisions. The advantages of entering into joint-working arrangements would allow the participating parties a say in developing management structures, pooling expertise and resources, better geographic demarcation and more integrated training opportunities. It is safe to assume that as things stand at the moment, there are probably a number of overlapping areas where different stakeholders, are pursuing the same aims, at different times and in different places in different ways. Undoubtedly, improvements in collaborative partnerships and less formal initiatives offer considerable scope for financial savings. On this basis, a more democratic involvement by NGO's in delivering services should empower both NGO's and local communities and ultimately service users.

5.5 Conclusion

The costs of mental health care have been rising annually and are set to continue to rise. There has been a continuous under-investment in mental health services, a fact that has been a cause of concern in many of the recent Mental Health Act Commissioners' Biennial reports. Recent reports suggest that direct mental health service care now costs around £22.5 billion a year, with 68% being provided by the NHS - 24% provided by non-statutory organisations and 7-8% provided by social services.⁶⁶¹ Projections indicate that these could rise to £32.59 billion by 2026. The cost analysis did not include indirect costs such as the prison service, lost revenue generated through taxation, consumer spending deficit or the cost of informal care provided by family carers. If the social (indirect) costs of mental health care are included, research suggests that the total cost of providing mental health services may exceed £80 billion by the year 2026.

⁶⁶¹ National Survey of Investment in Adult Mental Health Services 2009/10, Fig 6, p. 8.

With an increasingly ageing population, unless there are radical developments in the treatment of age-related mental illness, the provision for older people's mental health services is projected to account for more than half of all direct expenditure by 2026. The authors of the King's and the SCMH reports both comment on the difficulty of comparing data due to the various methodologies used over the years and that future projections of costs, based on current levels of investment, are at best conservative.

The realisation that these service costs are difficult to sustain in the long term, has seen a radical departure in policy from the traditional model of commissioning mental health services. Both New Labour and the Coalition have commissioned research into the impact of intervention-based strategies as cost effective means of delivering mental health services. Although it has been anticipated that there may be increased costs in the short-term, projected long-term benefits should provide better services for patients and considerable financial savings. Further government proposals towards the devolution of NHS services commissioning⁶⁶² and the Localisation Bill's move towards the de-centralisation of central government, have the potential to develop a more flexible community care model that would involve a considerable growth in third sector providers. Arguably, this would result in better delivery of front line services for patients, with additional economic benefits that would impact on the Treasury and the Department of Work and Pensions in terms of increased tax revenue, reduction in lost employment costs and fewer benefit payments. However, the recent comprehensive spending review, which has fixed spending, budgets for each Government department up to 2014-15, has set the total NHS budget at £114.4 billion.⁶⁶³ Under such difficult economic circumstances, funding for the future expansion of services, particularly those provided by NGO's may prove problematic, at least in the short-term.

⁶⁶² Health and Social Care Bill, The Health and Social Care Bill was introduced into Parliament on 19 January 2011. The Bill is a crucial part of the Government's vision to modernise the NHS so that it is built around patients. <http://www.dh.gov.uk/en/Publications/> Accessed 12th February 2011.

⁶⁶³ HM Spending Review 2010, Table 9, Total department expenditure limits.

As previously discussed, many of today's service user orientated NGO's originate from early beginnings as local self-help groups. Since then, the movement has grown from being service user led campaign lobbyists to becoming substantial providers of service user based expertise in mental health care.

More recently many NGO's have been active in both research and innovation, for example the *Principles of Self-management* partnership between Cardiff University and MDF Bi-Polar Organisation⁶⁶⁴ involved a successful bid for funding from the National Lottery. Joint collaboration on such projects provides many positive outcomes; the Cardiff MDF pilot benefits all stakeholders, although in different ways. The University gains funding and quality research data, MDF gains assistance with project management, and patients gain in the delivery of vital extra services. Other projects often fill in gaps in services that are not available through mainstream delivery. The CAB helps thousands of people every year at a grass-roots level and makes valuable contributions towards policy research; a recent partnership with Bangor University produced a joint report following a longitudinal study of Citizens' Advice Bureau clients in Wales,⁶⁶⁵ highlighting many of the problems that affect vulnerable groups in the population. Undoubtedly the role of third sector stakeholders has changed radically over the years with more organisations developing considerable expertise in their chosen fields and making valuable contributions to research and policy development.

Although the *No Health, Without Mental Health* strategy framework is at an early stage, evidence from other jurisdictions suggests that multi-agency partnerships will become more widespread. In Scotland, where the legislative reform process in mental health began earlier than in England and Wales, the Scottish Executive has made better mental health a target priority and has proactively funded innovative programmes such as the Scottish Mental Health First Aid scheme (SMHFA), which is now being rolled out in Wales supported

⁶⁶⁴ As previously discussed above.

⁶⁶⁵ Jones, K. (2009), Outcomes of a Longitudinal Study of Citizens Advice Service Clients in Wales, Bangor University & Citizens Advice Cymru.

by the Welsh Assembly Government and Mind Cymru.⁶⁶⁶ Similarly, in Australia and New Zealand, multi-agency cooperation between government departments and NGO's is now the norm.⁶⁶⁷

The advantages of collaborative partnerships are many-fold, rather than the top-down (and somewhat restrictive) approach that had been the norm since the early sixties, a more communitarian approach would provide a more horizontal distribution of funding, resources, expertise and risk and reward which ultimately should filter through to those that need support the most. The success of these partnerships suggests that the voluntary sector is successfully being 'mainstreamed' into government policy agendas.⁶⁶⁸ The National Council for Voluntary Organisations estimated that in 2005, around 90 per cent of local authorities in England have developed or were establishing a local compact with local service providers.⁶⁶⁹

It is evidential that first-line delivery of services is not the whole story; ancillary projects such as help-lines, community drop in centres and advocacy providers make an equally valuable contribution to promoting and sustaining conditions that encourage good mental health.

That there is now a proactive environment, which is based on increased multi-agency cooperation towards the commissioning of services according to local need and social inclusion as a fundamental part of government policy, should in the long-term, create the opportunities for the further reform and an equitable distribution of ESC rights. Undoubtedly, the immediate future for any further gains in ESC rights for mental health service users is going to develop through greater collaboration between government and the third sector rather than central government policy alone.

⁶⁶⁶ Welsh Assembly Government, <http://www.mhfa-wales.org.uk/adult/links-english/home.htm> Accessed 11th July 2011.

⁶⁶⁷ Australia's community services, ACOSS, Sydney. (2007) Australian Community Sector Survey, http://www.acoss.org.au/upload/publications/papers/2101__Community%20Sector%20Survey%202007.pdf, Accessed 12th January 2010.

⁶⁶⁸ Kendall, j. (2000), The mainstreaming of the third sector into public policy in England in the late 1990s, *Policy and Politics*, 28(4): pp. 541-62.

⁶⁶⁹ Cooke, S. & Vyhas, D. (2008), *Votes and Voices; the complementary nature of representative and participative democracy*. London, NCVO and The Local Government Association.

Conclusion

From the initial beginnings in the Chancery Courts where the protection of property was seen as the fundamental aim, towards the introduction of the poor law in the early seventeenth century, too a shift in the 'substance and nature' of mental disorder. The understanding of insanity itself has been subject to frequent re-interpreted by both the common law and statute. *Hadfields* and *McNaughtens* case's both influenced the criminal law and their fundamental conclusions regarding abnormality of the mind and culpability are still in use today.

In the late eighteenth and nineteenth centuries there was a notable move in the way in which the treatment of the mentally ill changed from piecemeal incarceration to a more humane and therapeutic awareness of care. Showing the beginnings of a more humanitarian attitude rather than the custodial approach that had for so long been the province of the private madhouses.

The beginning of the period of the 'great confinement,' following the County Asylums Act, began a long period of institutionalised care, (a positive development at the time), but also of a enduring pathway of ingrained thinking in policy, arguably, a negative pathway for further reform. History suggests that once established, institutions are, for a number of reasons difficult to change, Consequently, the asylum system continued to be the mainstay of mental health policy for most of the nineteenth and twentieth centuries.

The general climate in social thinking changed radically in the post war period with the birth of the welfare state in the UK. The European Convention of Human Rights brought considerable gains in generating a second wave of PC rights and ESC rights, addressing inequality at all levels of society. In terms of mental health reform, this was reflected in the willingness to reformed legislation, beginning with the Percy report and the MHA1959, the later 1983 Act and more recently, the closure of the old asylums under the Thatcher Government, followed by New Labour's shift in policy towards community care.

The transition towards a community-based system of care was not without its problems; following a number of high profile killings of members of the public by patients on release in the community. The killing of Jonathan Zito by Christopher Clunis immediately impacted upon public opinion, community care was no longer seen as a safe option. Now, not only did New Labour have to live up to its manifesto promises to reform mental health care, in the public's eyes, it had to be seen to be doing so. Almost overnight, the discourse changed from one of rights to one of risk. In addition, a number of cases in the European court of human rights suggested that the UK's mental health system was failing in more ways than one, suggesting that the time was once again ripe for reform, a process that began in 1998 with the Richardson Report.

Following a number of failed attempts to legislate anew, New Labour announced in 2006 that any further progress towards reform would be made by amending the existing legislation. Consequently, the move towards reform remained constrained on the premise of social control on the grounds of public interest and continuing medical paternalism on the basis of 'best interests.' A position that became energetically manifest as central to government policy in the infighting that followed during the Bill's parliamentary process.

Arguably, the MHA 2007 as a piece of amended legislation has done little to advocate a third wave of positive rights; it has for the most part been concerned with the Convention compliance of an existing body of law rather than the hoped for paradigm shift in care and treatment. Despite several improvements in safeguards regarding consent to treatment and detention, it is still for the most part identified as overly restrictive with statutory compliance as a central tenet. Many critics argued that unlike the earlier Scottish reforms, New Labour's reluctance to endorse humane principles on a statutory basis was out of step with the then prevailing human rights climate and failed to address the needs and aspirations of many of the interested stakeholders. Subsequently various actors argued that adhering too rigidly to compliance effectively consigned the 2007 Act as a restatement of PC rights rather than a positive change in direction towards a third wave of ESC rights. Many

commentators saw the introduction of compulsory community treatment as a reverse in what had hitherto been a positive move towards more ethical reforms. The result is that the Mental Health Act remains profoundly stigmatising, arguably, the 2007 Mental Health Act will go down in history as a missed opportunity.

There may as yet be further opportunities for a constructive dialogue towards a positive for duty on public agencies. The implementation of the Equality Act 2006 proposing the fusion of the Equal Opportunities Commission; the Commission for Racial Equality and significantly the Disability Rights Commission, coupled with the potential for choice promised by the proposed reforms to the NHS Constitution and the governments *New Horizons* strategy should provide a substantive platform for ESC rights. England and Wales have adopted the *New Horizons* consultation process as a way forward, acknowledging that among many of the issues, one of the greatest difficulties to be overcome in re-constructing what has come to be seen as institutionalised social exclusion, is the importance of improving the public's mental health literacy at a grass roots level and preventing the stereotypical reinforcement of stigma by the media.

From a service users point of view, being labelled as mentally ill is not just about the illness itself. In the eyes of others, there are often pre-conceived assumptions that the individuals are a potential danger themselves and to others, difficult to employ and incapable of making rational decisions regarding their own illness. This has been reinforced in part by the attitude of the medical profession, which conservatively has been based on a tradition of medical paternalism. The doctor patient relationship in the context of mental illness is one of coercive compliance, with the possibility of enforced treatment forever present. As discussed, many service users view the Mental Health Act as at its best, something to be avoided and at worst an equivalent to a prison sentence. Understandably, many service users view the psychiatric profession and the accompanying legislation as a measure of last resort. As Professor Dinesh Bhugra (as discussed in Chapter Three), the then president of the Royal College of Psychiatrists, admitted that the conditions in many

psychiatric wards in England and Wales are now so poor, that he would not use them himself - nor allow a member of his family to do so.

'You don't go to hospital to get hurt, but that's what's happening in our acute psychiatric wards...some are uninhabitable. It's completely and absolutely unacceptable.'

Unfortunately, many service users, especially those that have already been hospitalised, are only all too aware of the state of affairs that exist on many hospital wards, understandably, that such poor conditions continue, does little for patient confidence in a system that is still largely based on latent coercion. Though supervised community treatment is still in its infancy, there are real concerns over the availability of the resources needed to adequately manage patients in the community. With an uptake of just under 2000 orders issued in the first five months, the reported concerns over the shortage of second opinion doctors (SOAD's) could short-circuit the system in the short-term, fueling continuing disquiet over the long-term effectiveness of the program.

Inevitably, the availability of quality service delivery is always going to be a question of finite resources, with the current cost of direct services now exceeding 2007's expenditure of £22.5 Billion, continued spending within the conservative framework would be unsustainable. The governments *New Horizons* strategy would seem to indicate that the void that was previously filled by the third sector is to be reinforced by a more multi-disciplinary approach to service delivery. This would provide further opportunities for the equitable distribution of economic, social and cultural rights. The advantages of shared partnerships are many-fold, rather than the top-down approach that had been the model since the early sixties, a more communitarian approach would provide a more horizontal allocation of funding, resources, expertise and risk and reward, which in due course should filter through to those that need support the most. It is clear that first-line delivery of services is not the whole story; many auxiliary projects such as help-lines, drop-in-centres provide an equally important input in promoting good mental health. That there is now a positive environment, which is based on multi-agency collaboration as a fundamental part of government policy, should in the long-term create the

opportunities for further reform of ESC rights. Recent studies have argued for a broader approach to investment in services based on pro-active prevention, with considerable economic justification

What is clear from the various arguments considered in the writing of this thesis, is that there are two distinct threads of discussion; firstly, the reform to the MHA itself had been a source of considerable concern over civil liberties issues, chiefly those to do with the governments proposals for community treatment. However, even the Government's most hardened critics would have to acknowledge that there will always be a degree of necessity in using compulsion in the case of a very small number of patients. It is for this reason that the amendments fought for in the parliamentary process by those who were opposed to some of the overly restrictive proposals in the first draft of the Bill, reflect the new safeguards that are now part of English and Welsh law.

Secondly, any aspirations that amending the 1983 Act would provide a fundamental shift in the way in which services are delivered was always fundamentally flawed. The burden of providing good service provision extends far beyond the purpose of the Mental Health Act, which arguably should be rigidly interpreted in practice in a least restrictive approach as set out in the Code of Practice. Any further gains in ESC rights will for the most part remain beyond the remit of primary mental health legislation, it is anticipated that NGO's will play a greater part in the future direction of mental health care.

Glossary of Abbreviations and Acronyms

A/C	Approved Clinician
APMHP	Approved Mental Health Professional
ASW	Approved Social Worker
CMD	Common Mental Disorder
CMO	Chief Medical Officer
CoP	Code of Practice
CQC	Care Quality Commission
CSIW	Care Standards Institute for Wales
CTO	Community Treatment Order
DSM-IV.	Diagnostic and Statistical Manual of Mental Disorders (2000)
ECHR	European Convention on Human Rights
ICD-10.	International Classification of Diseases, 10 th Revision (1992)
IMHA	Independent Mental Health Advocate
LA	Local Authority
LHB	Local Health Board
LSE	London School of Economics
LSSD	Local Social Services Department
MCA	Mental Capacity Act 2005
MHA 1983	Mental Health Act 1983
MHA 2007	Mental Health Act 2007
MHAC	Mental Health Act Commissioners
M/O	Medical Officer
NGO	Non-Governmental Organisation
NSF	National Service Framework
PCT	Primary Care Trust
PSSRU	Personal Social Services Research Unit
R/C	Responsible Clinician
RMO	Responsible Medical Officer
SCMH	Sainsbury Centre for Mental Health
SHA	Strategic Health Authority

SOAD

Second Opinion Approved Doct

Appendix A

Case Law:

<i>Ashingdane v United Kingdom</i> [1985] 7 EHRR 528	67
³⁴ <i>F v west Berkshire HA</i> [1989] 2 All ER 545.	31
<i>Hadfields case</i> . State Trials 1800 v. 27	12, 13
<i>Herczegfaly v Austria</i> (1992), 15 EHRR 437	128
<i>H.L. v UK</i> 45508/99 (2004) ECHR 471	42
<i>Johnson v UK</i> (1997) 27 EHRR 296	39
<i>Lord Onslow's case</i> , State Trials 17	12
<i>JT v United Kingdom</i> [2000] 1 FLR 909 EctHR.	68
<i>Lewis v Gibson and MH (by her litigation friend the Official Solicitor)</i> [2005] EWCA Civ 587	68
<i>McNaughtens case</i> 10 Cl. & Fin. 200, 8 Eng. Rep. 718 (1843).	53, 54
<i>R (B) v Dr SS</i> (2006) EWCA Civ 28	128
<i>R v Barking Havering and Brentwood Community Healthcare NHS</i> [1999] 1 FLR 106	68
<i>R (k) v Camden and Islington Health Authority</i> (2001) EWCA Civ 240	40
<i>R v Hallstrom, ex parte W</i> [1986] QB 1090	81
<i>R v MHRT ex p. KB and seven others</i> , (2002) EWHC Admin 639.	39
<i>R v MHRT, ex pt, Clatworthy</i> [1985] 3 All ER 699	53
<i>R (on the application of CS) v Mental Health Review Tribunal and the Managers of Homerton Hospital (interested party)</i> [2004] EWHC 2958	81, 86
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